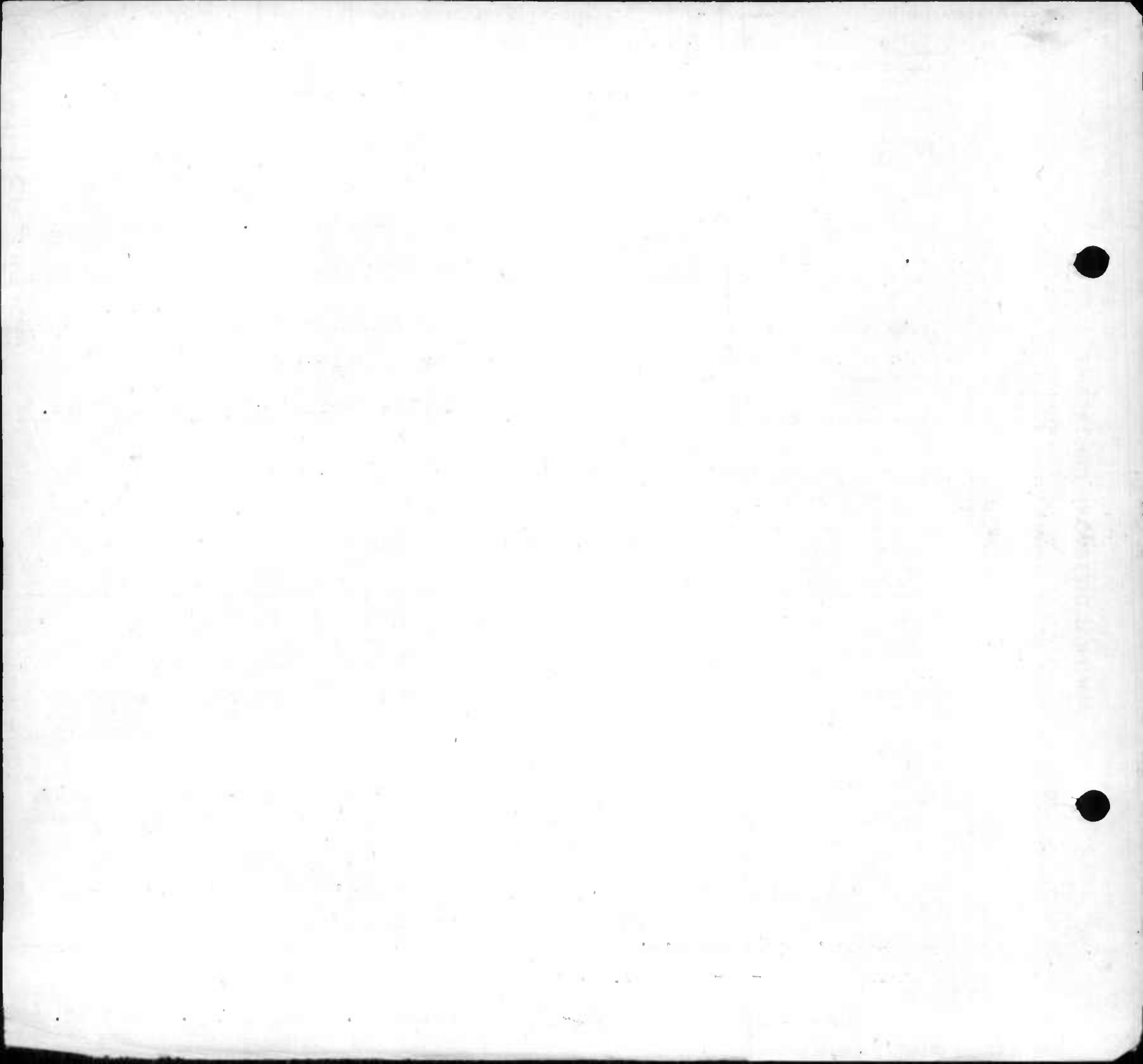


FUNERAL DIRECTOR: IMPORTANT

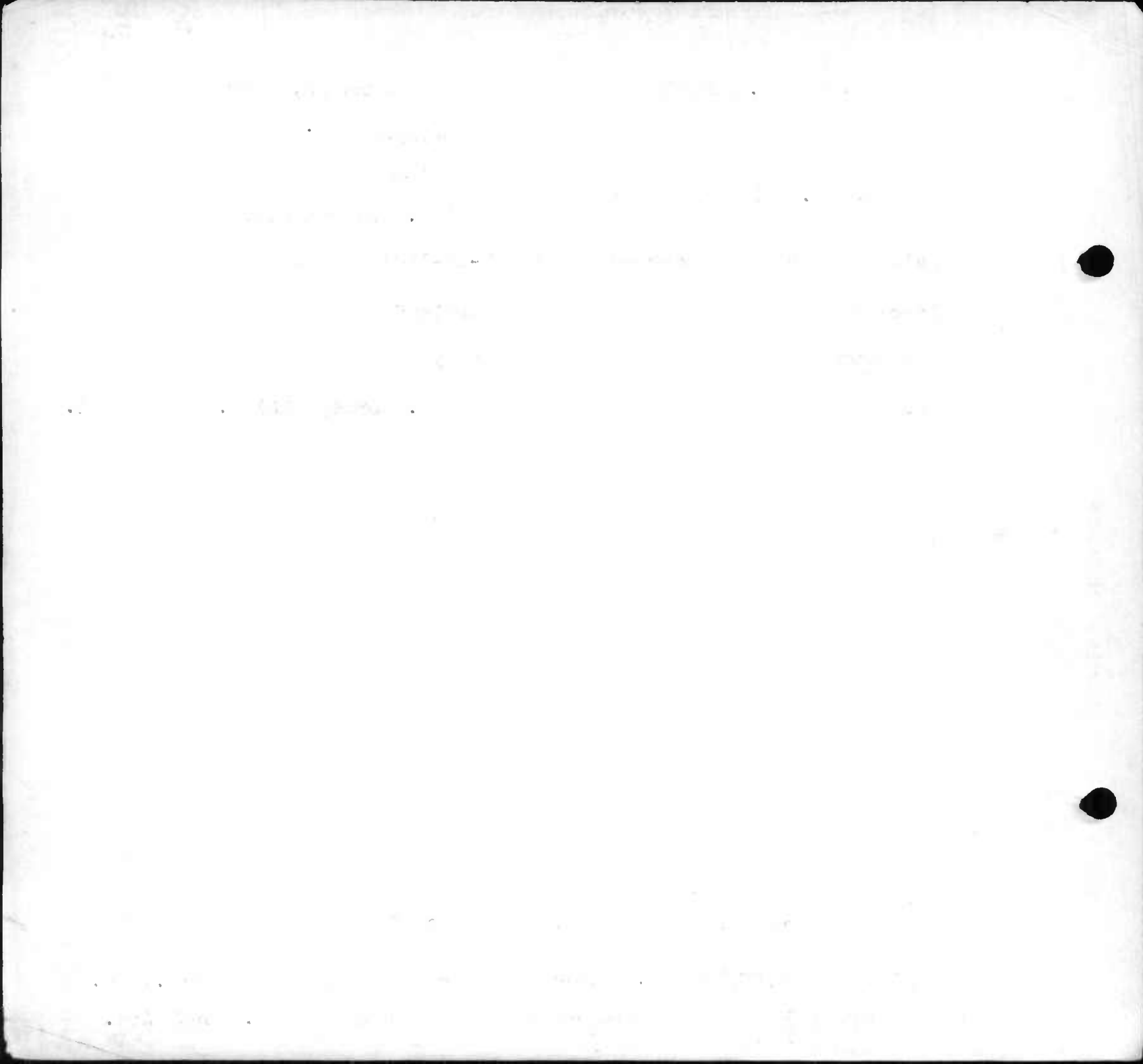
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6501
BIRTH NO. 70 6501		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Goldie Sappington		2. DATE AND HOUR OF DEATH 6/22/70 5:10 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 2841		
FULL NAME OF HOSPITAL OR INSTITUTION 00 4220 Fernhill Ave		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F.		6. RACE G		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) 12/25/98 71
13. FATHER'S NAME John Sappington		14. MOTHER'S MAIDEN NAME Mary Richardson		11. BIRTHPLACE (State or foreign country) Maryland
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
17. INFORMANT Cecelia Curtis 4220 Fernhill Ave.		ADDRESS		
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardio-vascular Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 8/27 19 49 to 6/22 19 70 , that (I) (we) lost saw the deceased alive on 6/22/70 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ralph W. Reckling M.D.				23B. DATE SIGNED 6/23/70
23C. PHYSICIAN'S NAME (Type) Ralph W. Reckling M.D.		23D. ADDRESS 2930 Baker Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-25-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, R.A.		25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 70 6502	
BIRTH NO. 70 6502		CERTIFICATE OF DEATH			
M.E. CASE NO.		DATE AND HOUR OF DEATH June 25, 1970			
1. NAME OF DECEASED (Type or Print) JAMES H. DORSEY		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1901			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 331 N. Calhoun Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 331 N. Calhoun Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2-14-1901	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lolly			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mary E. Dorsey 331 N. Calhoun St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Wide spread metastases		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ Adenocarcinoma of the left colon		INTERVAL BETWEEN ONSET AND DEATH 2 years	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert H. Johnson Jr M.D.				23B. DATE SIGNED 6/26/70	
23C. PHYSICIAN'S NAME (Type) Robert H. Johnson, Jr. M.D.				23D. ADDRESS University of Maryland Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70		24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 26 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm C March 928 E. North Ave.			



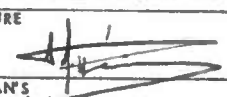
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

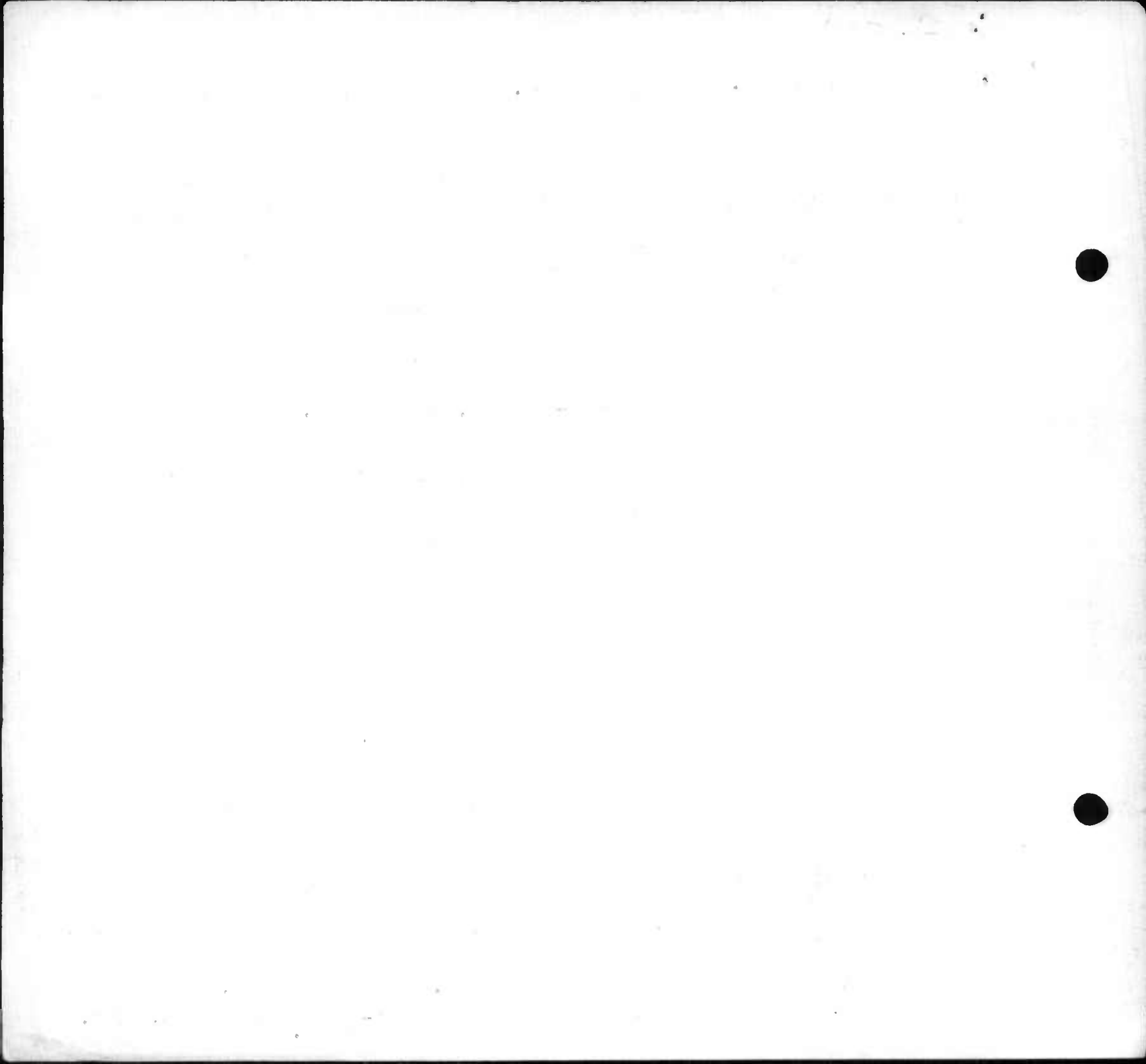
BALTIMORE CITY HEALTH DEPARTMENT				70 6503		REG. NO. 70 6503	
F-200				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) FOX, WESLEY (NMI)				2. DATE AND HOUR OF DEATH June 14, 1970 5:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1509 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3602 Lyndhurst Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/6/1884	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook Retired		10B. KIND OF BUSINESS OR INDUSTRY KERNAN HOSPITAL		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Fox				14. MOTHER'S MAIDEN NAME Elizabeth Ash			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7-31-18 to 7-21-19		16. SOCIAL SECURITY NO. 215-24-94-80		17. INFORMANT MRS. GLADYS WARDELL ADDRESS 2602 LYNHURST AVE.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ischemic necrosis of small bowel (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ Ischemic myocardial disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Ischemic myocardial disease							
19A. DATE OF OPERATION 6/5/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED abdominal pain, ischemic bowel		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from June 3, 1970 to June 14, 1970 that (X) (we) last saw the deceased alive on June 14, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE WALTER SMITHWICK, M.D.				23B. DATE SIGNED 6/17/70		23C. PHYSICIAN'S NAME (Type) Walter Smithwick MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/19/1970		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL CEM		24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE			

2602 Lynhurst Ave.

FUNERAL DIRECTOR: IMPORTANT

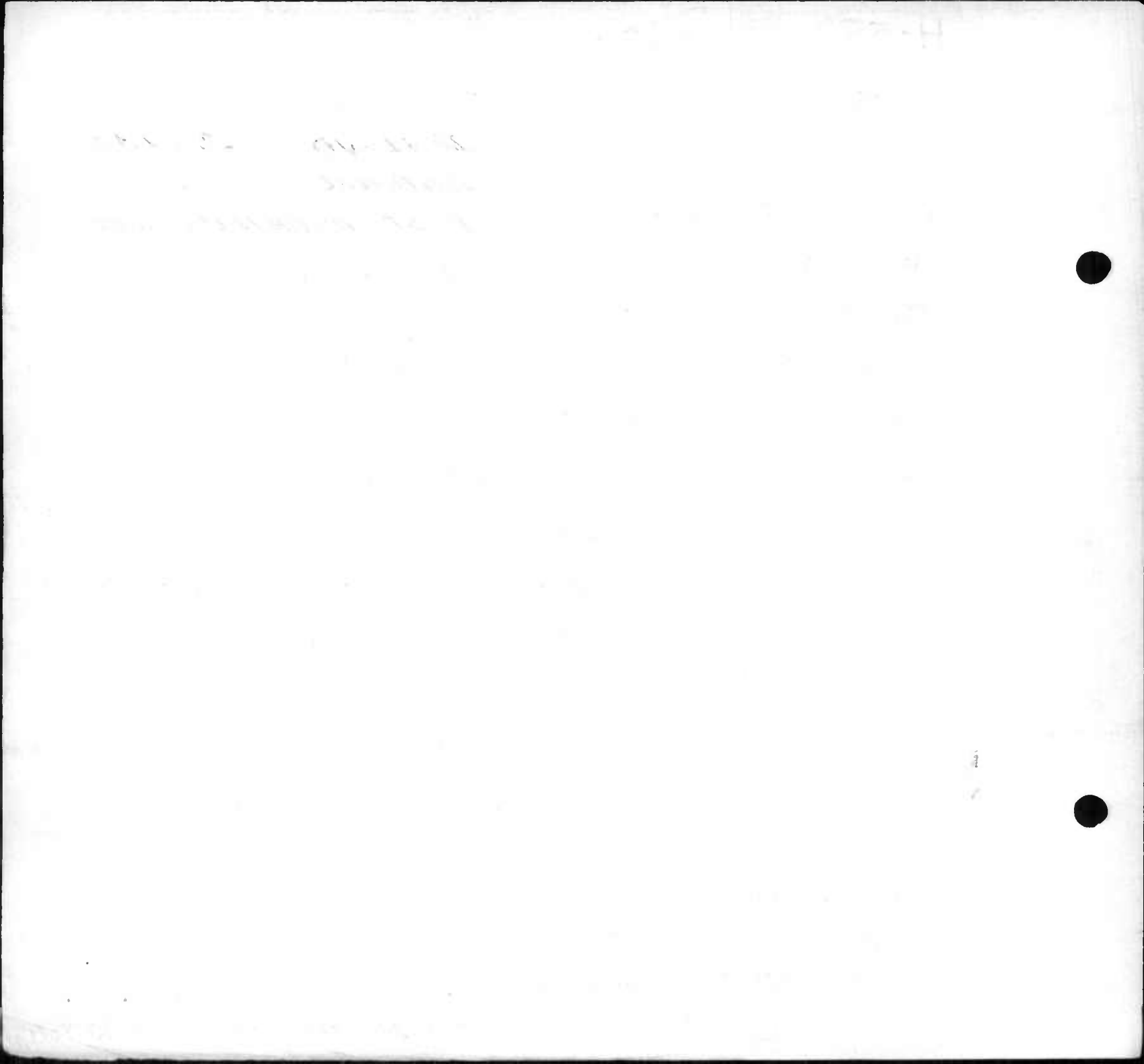
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6504	
70 6504				CERTIFICATE OF DEATH	
BIRTH NO. G-510		1. NAME OF DECEASED (Type or Print) GAMBO AMERICO J.		2. DATE AND HOUR OF DEATH 6/19/1970 5.30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND. B. COUNTY Baltimore.		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1403 JEFFERS RD. #04.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/04	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR			11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ERNESTO GAMBO			14. MOTHER'S MAIDEN NAME MARIA COLOMBO		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 050-03-7128		17. INFORMANT MR. AMERICO E. GAMBO (SON)
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE CEREBROVASCULAR ACCIDENT. DUE TO, OR AS A CONSEQUENCE OF: (B) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II PNEUMONIA. (L.L.L.G.).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/2 19 70 to 6/19 19 70 that (I) (we) last saw the deceased alive on 6/19 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 			M.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/19/70
23C. PHYSICIAN'S NAME (Type) ANDREAS A. PETSAS M.D.			23D. ADDRESS SINAI HOSPITAL OF BALTIMORE.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 6/22/70	24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.		24D. LOCATION (City, town, or county) (State) BALTO Co.	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1970		25B. NAME OF REGISTRAR Robert E. Varney		25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME, INC. 6500 YORK RD. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

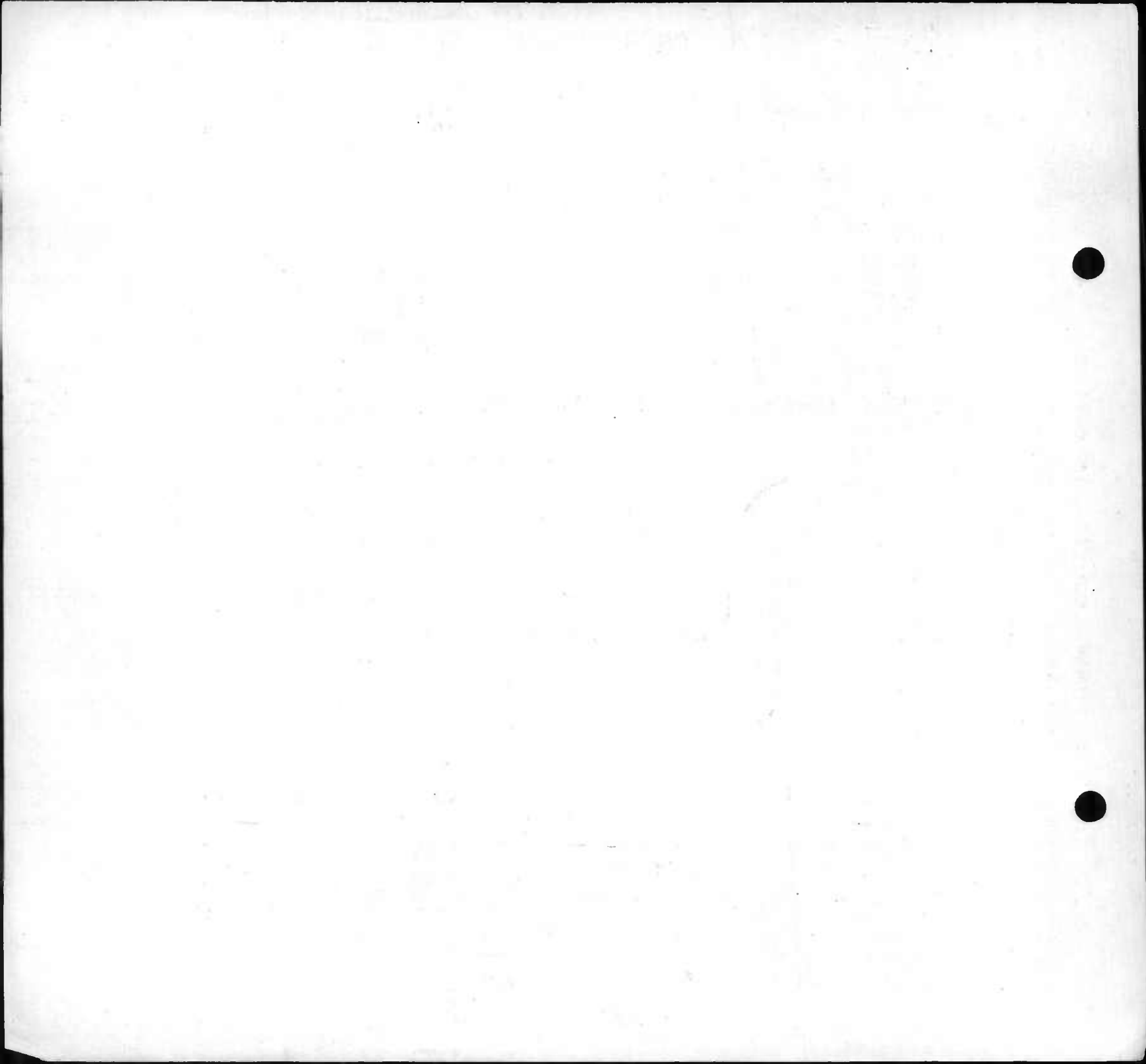
H-550		70 6505	BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X	REG. NO. 70 6505
1. NAME OF DECEASED (Type or Print) Hammen - Miss Geraldine Ott			2. DATE AND HOUR OF DEATH 6-18-1970 1127mid - M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Keswick 700 W. 40th St. - Baltimore - 1724-			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 8 ST. MICHAEL'S WAY			
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-8-1878	9. AGE (In years last birthday) 92 y 15	10. If Under 1 Yr. Months Days Hours Min. II Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Michael Z. Hammen			14. MOTHER'S MAIDEN NAME Rachel Elsbroad			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No			16. SOCIAL SECURITY NO. 220-44-3339		17. INFORMANT Keswick Medical Records -	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 433.91 + 250.9			CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis + hemiplegia (B) 2 weeks DUE TO, OR AS A CONSEQUENCE OF: Generalized arteriosclerosis (C) 20 years Diabetes mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5/12/70 19 to 6/19/70 19 that (I) (we) last saw the deceased alive on 6/19/70 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE W.B. Daniels, Jr. M.D.				23B. DATE SIGNED 6/19/70		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) W.B. Daniels, Jr.				23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/22/70		24C. NAME of CEMETERY or CREMATORY DRUID RIDGE CEMT.		24D. LOCATION (City, town, or county) PIKESVILLE BALTO. MD.
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MITCHELL WIEDEFELD HOME		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-516		70 6506		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6506	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Linaburg, Bernard L.</i>			
2. DATE AND HOUR OF DEATH <i>6-23-70 10:50 AM</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Mount Pleasant Convalescent Home 4615 Park Heights Ave</i>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>21211</i>				5. SEX <i>Male</i> 6. RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN <i>Balto</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <i>3307 Paine St</i>			
8. DATE OF BIRTH <i>1-15-27</i> 9. AGE (In years lost birthday) <i>43</i>				10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>			
10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <i>Md</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Leslie Linaburg</i>			
14. MOTHER'S MAIDEN NAME <i>Elizabeth Penner</i>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes Korean</i>			
16. SOCIAL SECURITY NO. <i>217-20-5531</i>				17. INFORMANT <i>Naomi Sullivan</i> ADDRESS <i>3354 Chestnut Ave</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of the Colon</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i>				(B) <i>Carcinoma of the Colon</i> DUE TO, OR AS A CONSEQUENCE OF: <i>2 yrs</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Renal Insufficiency 2nd degree</i>				(C) <i>2m 46</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6/13/70</i> to <i>6/23/70</i> and that (I) was lost saw the deceased alive on <i>6/13/70</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
23A. SIGNATURE <i>Harvey S. Feuerman</i> DEGREE				23B. DATE SIGNED <i>6/23/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Harvey S. Feuerman</i> DEGREE	
23D. ADDRESS <i>1401 Reisterstown Rd</i>				24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6-26-70</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>				24D. LOCATION (City, town or county) (State) <i>Baltimore Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUN 26 1970</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>				25C. FUNERAL DIRECTOR <i>Frank H. Seitz</i> ADDRESS <i>814 W 36th St</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED - 7/1/70

BALTIMORE CITY HEALTH DEPARTMENT		70 6507		REG. NO. 70 6507	
BIRTH NO. 8-435 70 6507		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BOLTON JOHN		2. DATE AND HOUR OF DEATH 6/23/70 8:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN Hospital of Md		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1916 N BENTLEY STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1895 7-4-42	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET.		10B. KIND OF BUSINESS OR INDUSTRY WESTERN UNION		11. BIRTHPLACE (State or foreign country) S. CAR.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN			
16. SOCIAL SECURITY NO. 212-03-8360A		17. INFORMANT Alice Bond ADDRESS 1916 BENTLEY ST.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 410.91 ACUTE MYO. INFARCTION CONGESTIVE HEART FAILURE ASCVD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-22-1970 to 6-23-1970 that (I) was last saw the deceased alive on 6-23-1970 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.					
23A. SIGNATURE Raymond P. Gandhi MD.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/23/70	
23C. PHYSICIAN'S NAME (Type) RATINDER P. GANDHI		23D. ADDRESS 730 ASHBURTON ST. BALTIMORE MD. 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) MD.			
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles R. Law ADDRESS 802 Madison Ave	

7/1/70 - Correction form from Federal Director.
A.C.

B-530 70 6508 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 6508

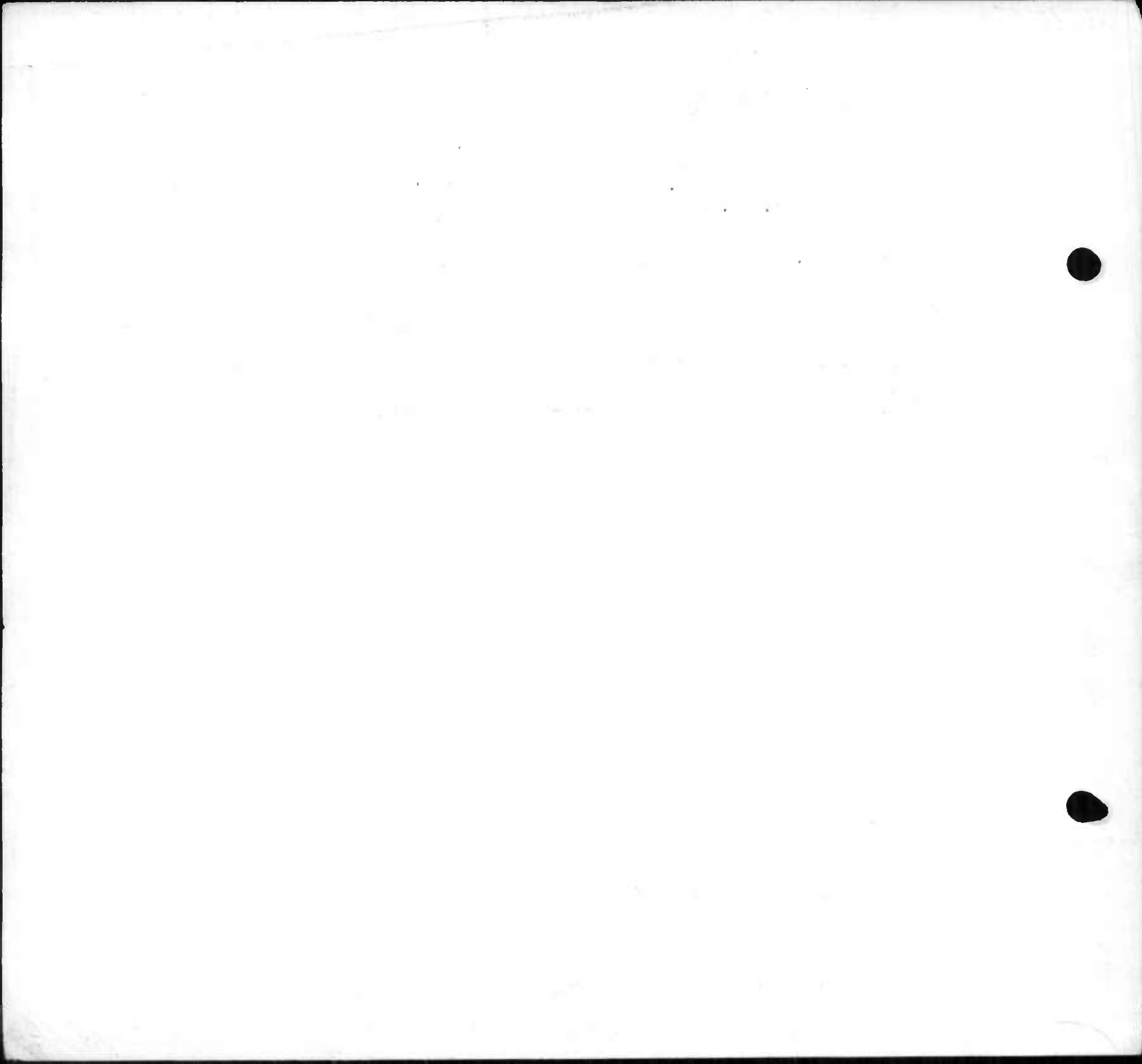
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM BUNDY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 516 N. Carrollton Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour June 24, 1970 10:40 P.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1601	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-8-1893		10. AGE (In years last birthday) 76	11. BIRTHPLACE (State or foreign country) King & Queen Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Bundy		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME Mary Johnson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. 214-01-5131		18. INFORMANT Mrs. Beulah Johnson 507 W. Ingham Ave N.J.	
19. 4-12-71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: June 25, 1970					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-70		24C. NAME OF CEMETERY or CREMATORY Greenwood Cemetery	
24D. LOCATION (City, town, or county) (State) Trenton, New Jersey		24E. NAME OF REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR MORTON & DYETT F.H.	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.	
25D. ADDRESS 1701 Laurens Street					

ACADEMY ROOM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6509		REG. NO. 70 6509	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Marconi, Agata				2. DATE AND HOUR OF DEATH 6/22/70 7:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HILTON NURSING HOME 3313 Poplar St. Balti. Md. 21216				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 21223 C. CITY OR TOWN Balt. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 512 parksley Ave			
5. SEX Female	6. RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/80	9. AGE (in years last birthday) 90	11. BIRTHPLACE (State or foreign country) ITALY		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? ITALY		
13. FATHER'S NAME CHRISTOPHER NOBLI			14. MOTHER'S MAIDEN NAME ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-16-6949		17. INFORMANT Hosp records		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 7/12/41 A. S. C. U. D.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-15-1970 to 6-22-1970 that (I) (we) last saw the deceased alive on 6-22-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Barbara Collier				23B. DATE SIGNED 6-23-70		23C. PHYSICIAN'S NAME (Type) Robert E. Farber, M.D.	
23D. ADDRESS 322 S. High St.							
24A. BURIAL CREMATION, REMOVAL (Specify) 6/26/70 Burial		24B. DATE 6/26/70		24C. NAME OF CEMETERY OR CREMATORY New Cath.		24D. LOCATION (City, town, or county) (State) Balt. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 26 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Frank Villalobos		ADDRESS 322 S. High St.	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) JAMES E. COMEGYS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1606 McCulloh Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 24, 1970 10:45 A.M.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 2/21/95		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 75		E. STREET AND NUMBER 1606 McCulloh Street	
11. BIRTHPLACE (State or foreign country) Baltimore M.		12. CITIZEN OF UNWAS COUNTRY?	
13. FATHER'S NAME ?		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) W W		17. SOCIAL SECURITY NO.	
18. INFORMANT Miss Susie Wilson, 2210 McCulloh St		ADDRESS	
19. 412.4-188X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Carcinoma of Bladder.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (Partial)		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> (Partial)	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/24/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70	
24C. NAME OF CEMETERY OR CREMATORY Louden Park National		24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Talbot, M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

ACADEMY BOND

VALLEY BAPTIST CH

415-1011-1111

T-650 70 6511 BALTIMORE CITY HEALTH DEPARTMENT X
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 6511

1. NAME OF DECEASED (Type or Print) JAMES THORNE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 6 Day 27 Year 70 Hour 5:20 P.M. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hosp.		3. DATE PRONOUNCED DEAD Month 6 Day 27 Year 70 Hour 5:20 P.M.	
6. SEX M		7. RACE Neg.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Plainsfield	
9. DATE OF BIRTH Nov. 3, 1943		10. AGE (In years, last birthday) 26	
11. BIRTHPLACE (State or foreign country) LITTLETON N.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JOHN THORNE		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
15. MOTHER'S MAIDEN NAME SARAH AUSTIN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 218-44-9289		18. INFORMANT JOHN THORNE ADDRESS LITTLETON N.C.	
19. E9661		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Stab wound of chest	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2626 Clewely Ave. 833		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 6 27 70 5:20 P.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? stabbed during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Walter U. Spitz EXAMINER'S NAME (Type)		DATE SIGNED 6-28-70	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 6-30-70	
24C. NAME OF CEMETERY or CREMATORY Family CEMETERY		24D. LOCATION (City, town, or county) (State) LITTLETON N.C.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Calvin B. Scrubbs		ADDRESS 1412 E. Preston St.	

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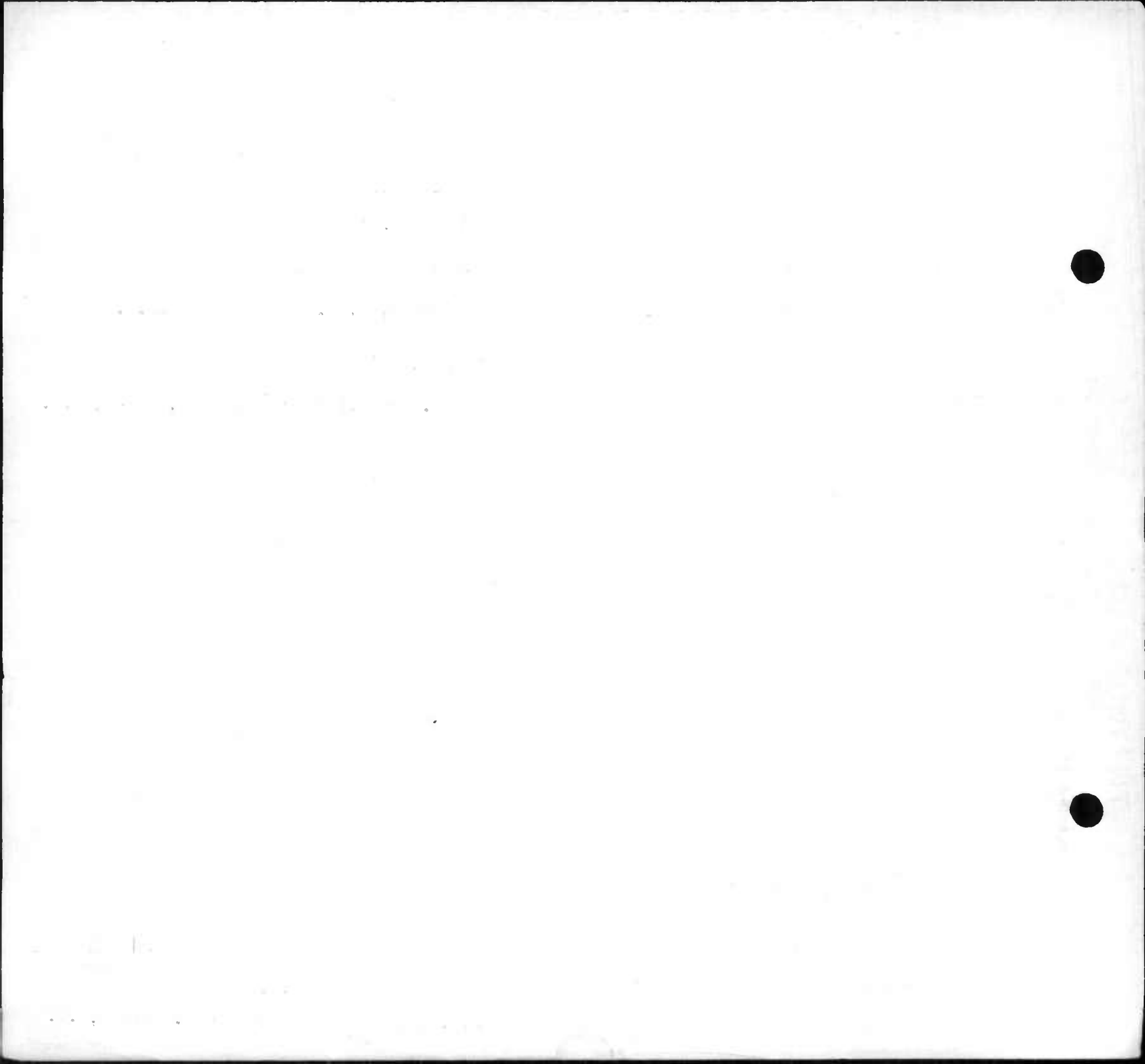
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

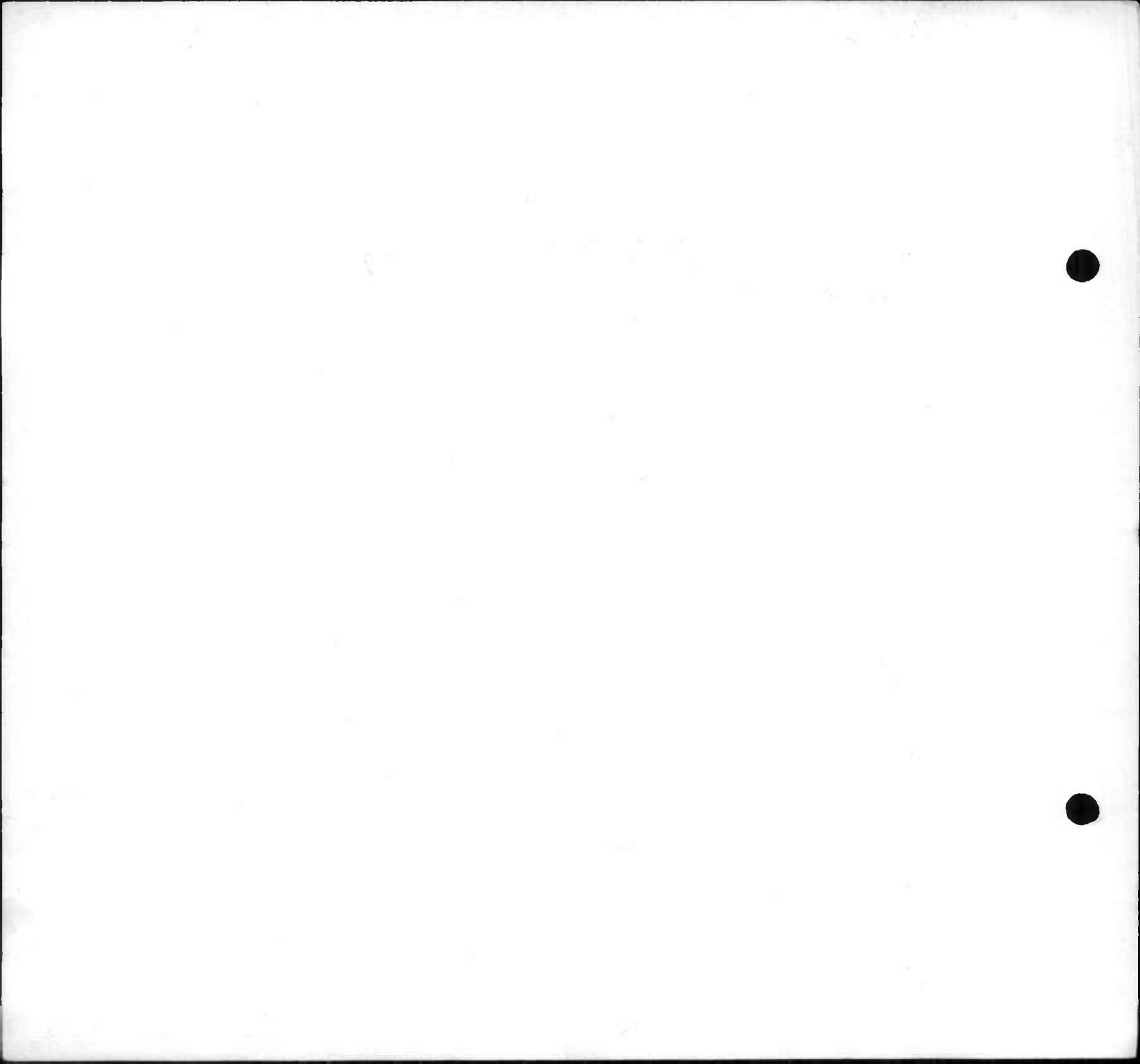
G-650 70 6512		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6512	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOSEPH GREEN		2. DATE AND HOUR OF DEATH June 26, 1970 3:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 33 JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1900 N. CHESTER STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-21	9. AGE (In years last birthday) 49	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothes Presser		10B. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Lewisburg, N. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS GREEN			
14. MOTHER'S MAIDEN NAME Alvarata Spivey		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Betty L. Green, 1210 Gmorreene Rd, Durham, N.C.			
18. 59901		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA BILATERAL		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) URINARY TRACT INFECTION + SEPSIS DUE TO, OR AS A CONSEQUENCE OF:		3 days	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CHRONIC ALCOHOLISM				20 yrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from June 24 1970 to June 26 1970 that (2) (we) last saw the deceased alive on June 26 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen P. Achuff		23B. DATE SIGNED June 26, 1970		23C. PHYSICIAN'S NAME (Type) STEPHEN ACHUFF	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/70		24C. NAME of CEMETERY or CREMATORY Beach Wood	
24D. LOCATION (City, town, or county) (State) Durham, N.C.					
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR J.C. Scarborough Funeral Home, Durham, N.C.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

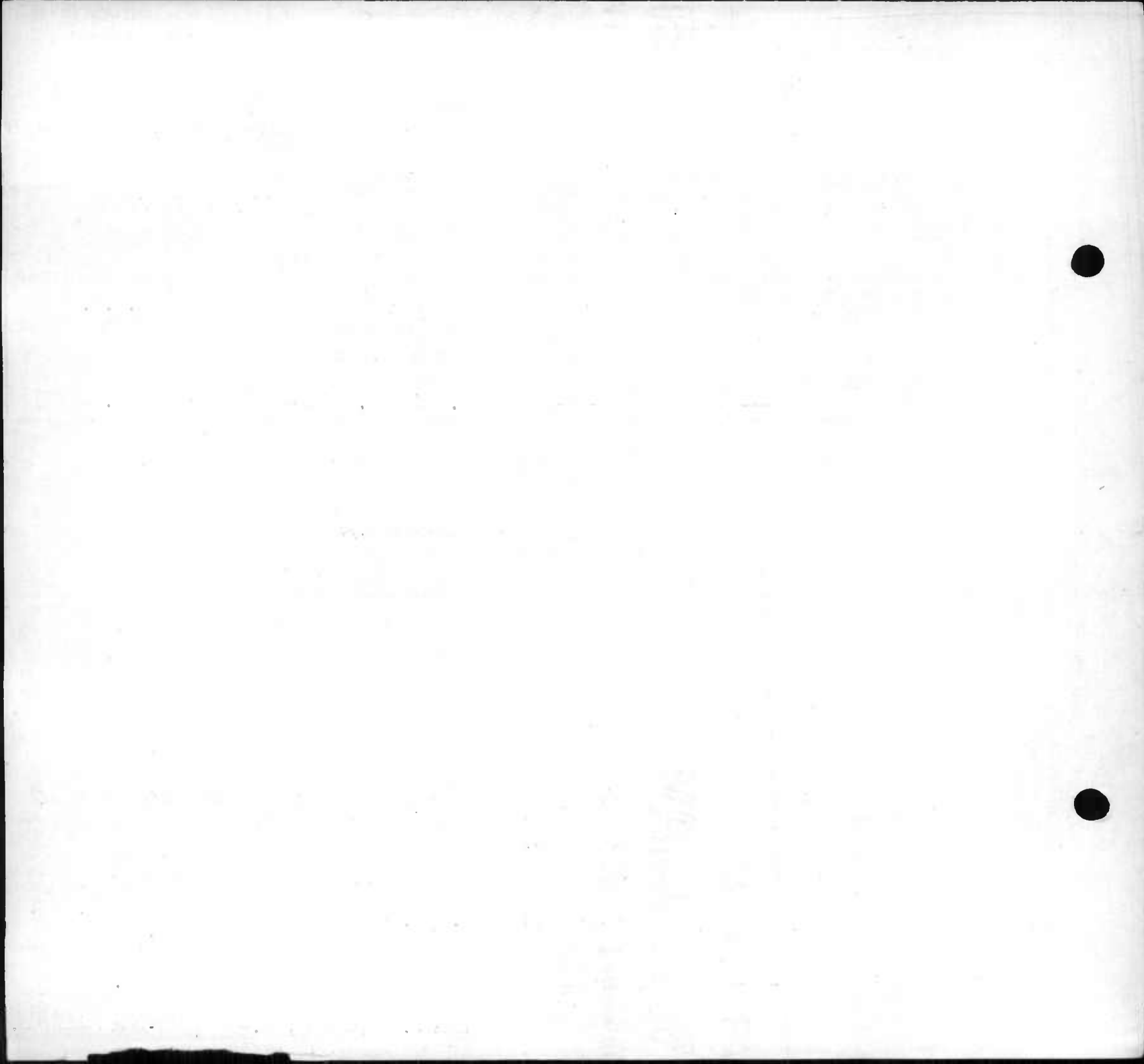
C-430 70 6513		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		REG. NO. 70 6513	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MR. THOMAS COLETT			
2. DATE AND HOUR OF DEATH 6-25-70 11:50 A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL 48				A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 4 TIPPERARY CT.							
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-97	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of two years immediately preceding death) RETIRED BALD. CITY				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Thomas Collett				14. MOTHER'S MAIDEN NAME UNKNOWN Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES				16. SOCIAL SECURITY NO. 212-07-5471		17. INFORMANT DORIS C. WARFIELD ADDRESS (SAME)	
18. 15-3014-2509 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
19. ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE METASTATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF: 1 yr			
20. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ADENOCARCINOMA OF RIGHT COLON DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CONGESTIVE HEART FAILURE, DIABETES MELLITUS			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) No			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) No		21E. INJURY OCCURRED While At <input checked="" type="checkbox"/> No Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? No			
22. I certify that (H) (this hospital) attended the deceased from 6-10 19 70 to 6-25 19 70 that (H) (we) last saw the deceased alive on 6-25 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William J. Quisenberry M.D.				23B. DATE SIGNED 6-25-70		23C. PHYSICIAN'S NAME (Type) WILLIAM QUISENBERRY M.D.	
23D. ADDRESS MD. GENERAL HOSPITAL BALD. MD							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 29-1970		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) BALD MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR C. F. EVANS		ADDRESS 5802 HARFORD RD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6514	
S-530 70 6514				REG. NO. 70 6514	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SMITH CHARLES O.			2. DATE AND HOUR OF DEATH 6/26/70 11:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MD. 730 ASHBURTON ST. BALTIMORE. MD. 21216			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 21229 C. CITY OR TOWN BALTIMORE. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1104 WALNUT AVE. 284		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-92	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME Ruth Parks		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-9933		17. INFORMANT ADDRESS Mrs. Vida B. Smith-1104 Walnut Ave. 21229	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DIFFUSED CARCINOMATOSIS. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. UREAMIA.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6-17 1970 to 6-26 1970 , that (I) (we) last saw the deceased alive on 6-26 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Rajinder P. Gandhi			23B. DATE SIGNED 6/26/70		
23C. PHYSICIAN'S NAME (Type) RAJINDER P. GANDHI			23D. ADDRESS 730 ASHBURTON ST. BALTIMORE. MD 21216.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-70		24C. NAME OF CEMETERY or CREMATORY Laydon Park	
24D. LOCATION Baltimore		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS John T. Stansbury, Sr. - 6411 Windsor Mill Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6515
I-208 70 6515				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ISAAC FOX		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH JUNE 25, 1970 1:05 P M.		
FULL NAME OF HOSPITAL OR INSTITUTION LEVINDALE HEBREW HOME & INFIRMARY		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2717		
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 4-1884		9. AGE (In years lost time) 86		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BLDG. CONTRACTOR		11. BIRTHPLACE (State or foreign country) RUSSIA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SAMUEL FOX		
14. MOTHER'S MAIDEN NAME SARAH ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT MR. SAMUEL FOX, 3 COBBLESTONE CT., APT. 2A		
18. 9/2/4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio vas - RENAL FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES - Partial
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 19 70 to 19 70 and that (I) (we) last saw the deceased alive on 6/25 and that in (my) (our) opinion death occurred on the date 6/26 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Elsa R. Merani		23B. DATE SIGNED 6/26/70		23C. PHYSICIAN'S NAME (Type) ELSA R. MERANI, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-26-70		24C. NAME OF CEMETERY or CREMATORY PETACH TIKVAH
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		
25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR GOL LEVINSON & BROS., 6010 REISTERSTOWN RD.		

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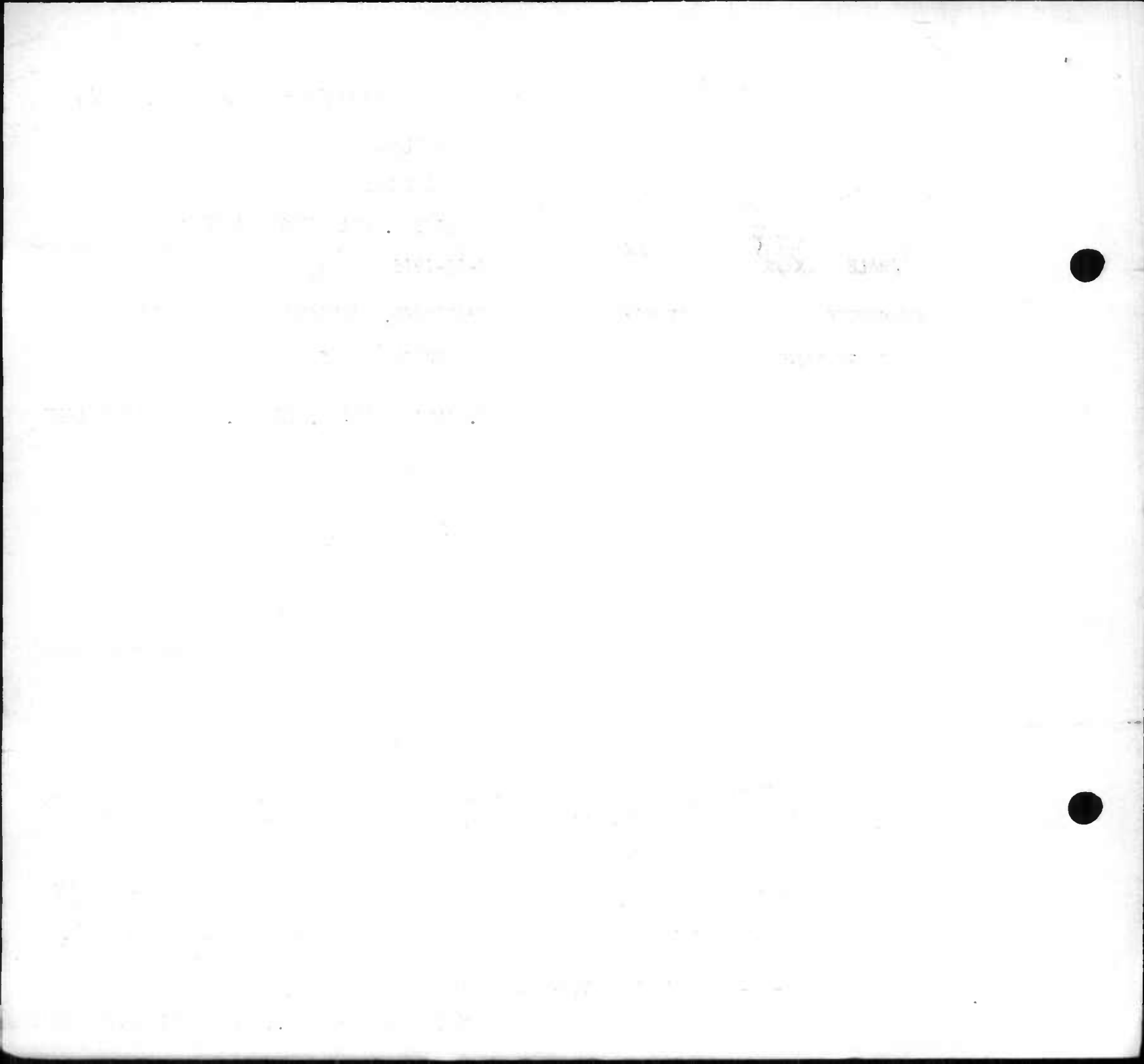
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

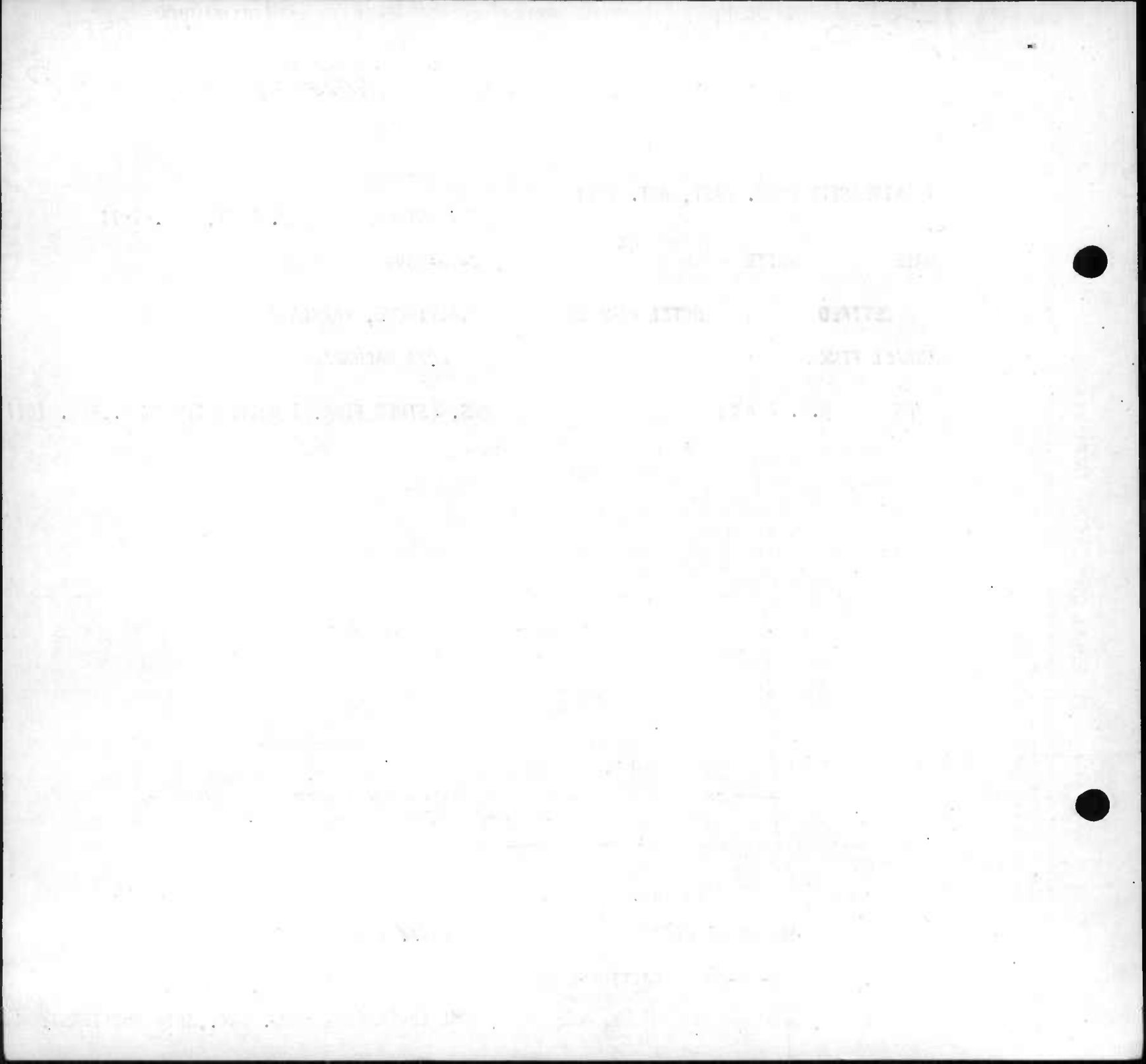
I-630 70 6516		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6516	
1. NAME OF DECEASED (Type or Print) FRIED, DAISY		2. DATE AND HOUR OF DEATH 11:47 AM June 25 '70 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSP. OF BALTO.		4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE MARYLAND B. COUNTY 1716			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-19-1912		9. AGE (In years last birthday) 58		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BENJAMIN SACHS		14. MOTHER'S MAIDEN NAME SARAH ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. ABRAHAM FRIED, 2508 W. COLD SPRING LANE	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: M. I. (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD. (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10:05 AM 6/25 1970 to 11:47 AM 6/25 1970 that (I) (we) last saw the deceased alive on 11:45 AM 6/25 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hyun Taik Oh		23B. DATE SIGNED 6/25 '70		23C. PHYSICIAN'S NAME (Type) HYUN TAIK OH	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-26-70		24C. NAME OF CEMETERY or CREMATORY HAR ZION TIFERETH ISRAEL	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Abraham Fried, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6517</u>
I-520 70 6517		CERTIFICATE OF DEATH		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>HAROLD I. FINK</u>		2. DATE AND HOUR OF DEATH <u>JUNE 24 1970 7:30 P.M.</u>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>1 UNIVERSITY PKWY. EAST, APT. 1011</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>1202</u>		
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1 UNIVERSITY PKWY. EAST, APT. 1011</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-1894</u>	9. AGE (In years lost birthday) <u>76</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOTEL MANAGER</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>
13. FATHER'S NAME <u>ISRAEL FINK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES W.W. I ARMY</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. ESTHER FINK, 1 UNIVERSITY PKWY., APT. 1011</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>4339 17 250.9</u> <u>Cerebral Thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 MOS.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus</u>		<u>10 YRS.</u>		
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 15 1949</u> to <u>June 24 1970</u> , that (I) (we) lost saw the deceased alive on <u>June 24 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Albert H. Himelfarb</u> DEGREE				23B. DATE SIGNED <u>6/25/70</u>
23C. PHYSICIAN'S NAME (Type) <u>ALBERT HIMELFARB</u>		23D. ADDRESS <u>222 COLD SPRING LANE</u> DEGREE		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>6-26-70</u>	24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 6518</u>	
BIRTH NO. <u>5-200 70 6518</u>				1. NAME OF DECEASED (Type or Print) <u>SACHS, Abe</u>		2. DATE AND HOUR OF DEATH <u>6-25-70 11:30 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL, BALTIMORE</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2719</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>9-5-1897</u> 9. AGE (In years lost birthday) <u>72</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAMPLE MAKER</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAMPLE MAKER</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING MFG.</u>		11. BIRTHPLACE (State or foreign country) <u>LATVIA</u>	
13. FATHER'S NAME <u>HYMAN SACHS</u>				14. MOTHER'S MAIDEN NAME <u>FRIEDA ?</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. SARAH SACHS, 3952 W. NORTHERN PKWY. #15</u>	
18. <u>422.3</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Heart Block</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Pacemaker Failure.</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Heart Block</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) <u>Pacemaker Failure.</u>							
19A. DATE OF OPERATION <u>6-22-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-22-1970</u> to <u>6-25-1970</u> that (I) (we) last saw the deceased alive on <u>6-22-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sullinko</u>				23B. DATE SIGNED <u>6-25-70</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>DR. SAGBE K. IKIRIKO</u>				23D. ADDRESS <u>SINAI HOSPITAL, BALTIMORE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-26-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ANSHE EMUNAH</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE RECD BY HEALTH DEPT. <u>JUN 29 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Sully, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	

[REDACTED]

1. The first part of the report

is a general description of the

area and the results of the

survey. It includes a map of the

area and a table of the results.

The second part of the report

is a

discussion of the results and the

conclusions. It includes a

summary of the results and the

conclusions.

1. The first part of the report

is a general description of the

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6519

BIRTH NO.

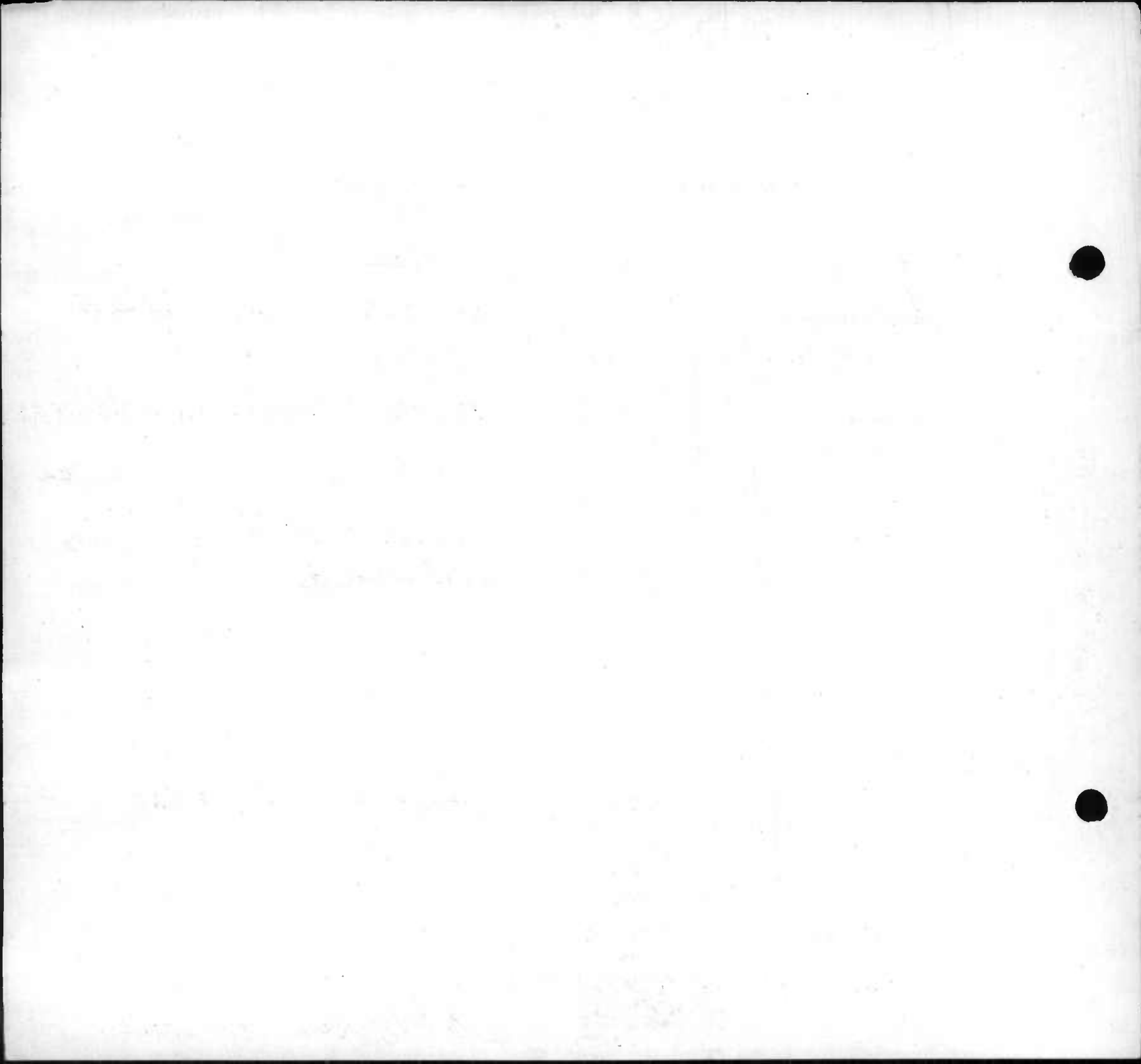
1. NAME OF DECEASED (Type or Print) LEONARD MOULSDALE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 25 1970 2:05 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore	
9. DATE OF BIRTH 10-19-1918		10. AGE (in years lost birthday) 52	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Employed		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-07-2036	
18. INFORMANT Mrs. Mary R. Mousdale, 270 Clyde Ave. 21227		13. FATHER'S NAME Leonard R. Mousdale, Sr.	
15. MOTHER'S MAIDEN NAME Mary R. XXXXXXXX (Unknown)		19. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Isidore Mihalakis</i> M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-26-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-27-1970	
24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Anne Arundel Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

Letter from M.E.'s office 7-21-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 6520	
C-252 70 6520		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Ella Cushing</u>			2. DATE AND HOUR OF DEATH <u>6/24/70</u> <u>7:20 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bolton Hill Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2572</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bolton Hill Nursing Home</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>7</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>11/9/82</u>		9. AGE (In years lost birthday) <u>87</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Baltimore - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Willie Wheatley Marks</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Jerry</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>213-54-1843</u>		17. INFORMANT <u>HOWARD F. SNYDER</u> ADDRESS <u>Above Address</u>
18. <u>277X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>anti coronary occlusion</u> <u>minutes</u> (B) <u>antecedent heart disease</u> <u>yes</u> (C) <u>marked obesity</u> <u>yes</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/16/70</u> 19 <u>70</u> to <u>6/24</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>6/24</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>6/25/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MAERT</u>				23D. ADDRESS <u>2 E Red St Baltimore Md</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-29-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Linden Park Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore - Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>McElly</u>		25D. ADDRESS <u>130 E. Fort Ave.</u>			



70 6521

BALTIMORE CITY HEALTH DEPARTMENT

70 6521

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN MARSHAL FORBES		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> June 20, 1970		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) (Mt. Carmel Cemetery) 6100 O'Donnell Street		3. DATE PRONOUNCED DEAD Month Day Year June 20, 1970		Hour 6:30 P.	
5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 203					
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH MARCH 12 1911		10. AGE (In years last birthday) 59		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) GOSHEN VIRGINIA		12. CITIZEN OF USA.		E. STREET AND NUMBER 1623 Thames Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		14B. KIND OF BUSINESS OR INDUSTRY BETH STEEL CORP		15. MOTHER'S MAIDEN NAME ADD A RANDOLPH	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES 1930-1937		17. SOCIAL SECURITY NO. 023-12-2382		18. INFORMANT LELIA FORBES ADDRESS 1225 GREGOR WAY 21224	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.41 (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: June 21, 1970					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 20 1970		24C. NAME OF CEMETERY or CREMATORY ST PAUL'S CEM.	
24D. LOCATION (City, town, or county) (State) BOSTON ST BALTO MD		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970			
25B. NAME OF REGISTRAR CLARENCE J. [illegible]		25C. FUNERAL DIRECTOR THE DUPRE BROS INC 1800 E LOMBARD ST.			

11

ALBERT L. FORD

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W-363 70 6522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6522

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ronnie Woodard				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 6 22 70 8:22 a. M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Hopkins Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 6 22 70 8:22 a. M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 103							
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Jan 6 - 1954		10. AGE (In years lost birthday) 17	11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2304 Essex St.		
11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Paul Woodard		
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Georgia ?		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			17. SOCIAL SECURITY NO. None		18. INFORMANT Paul Woodard		ADDRESS Same as above
19. E966 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 2304 Essex St. 103			
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 6 21 70 12:05		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot during altercation			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/23/70							
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 6/23/70		24C. NAME of CEMETERY or CREMATORY Cross Rd. Baptist Church Cem.		24D. LOCATION (City, town, or county) (State) Chesterfield Co. S. Carolina	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR G. H. Whitley		ADDRESS North Carolina	

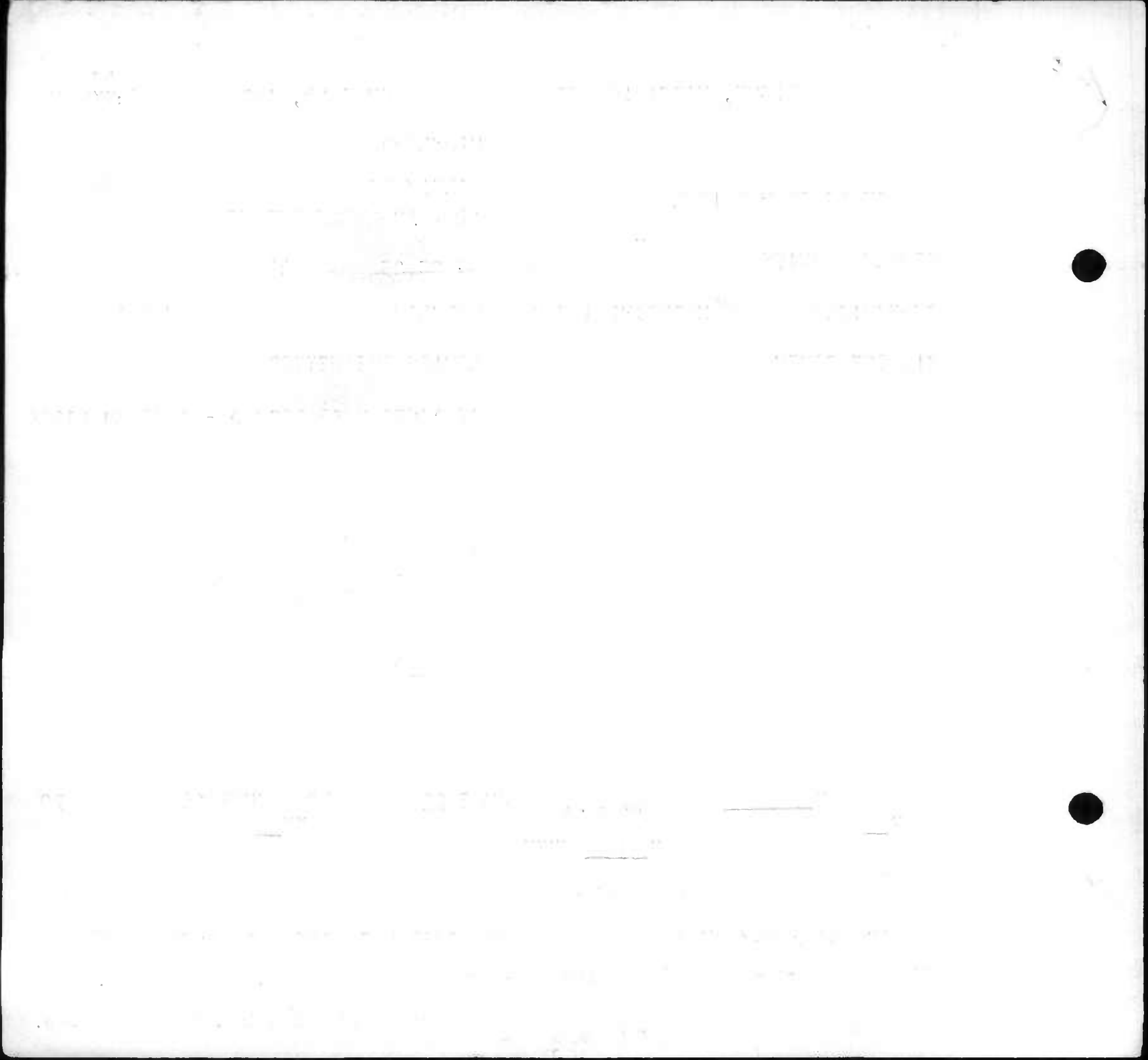
[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into paragraphs and possibly a list or table structure.]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

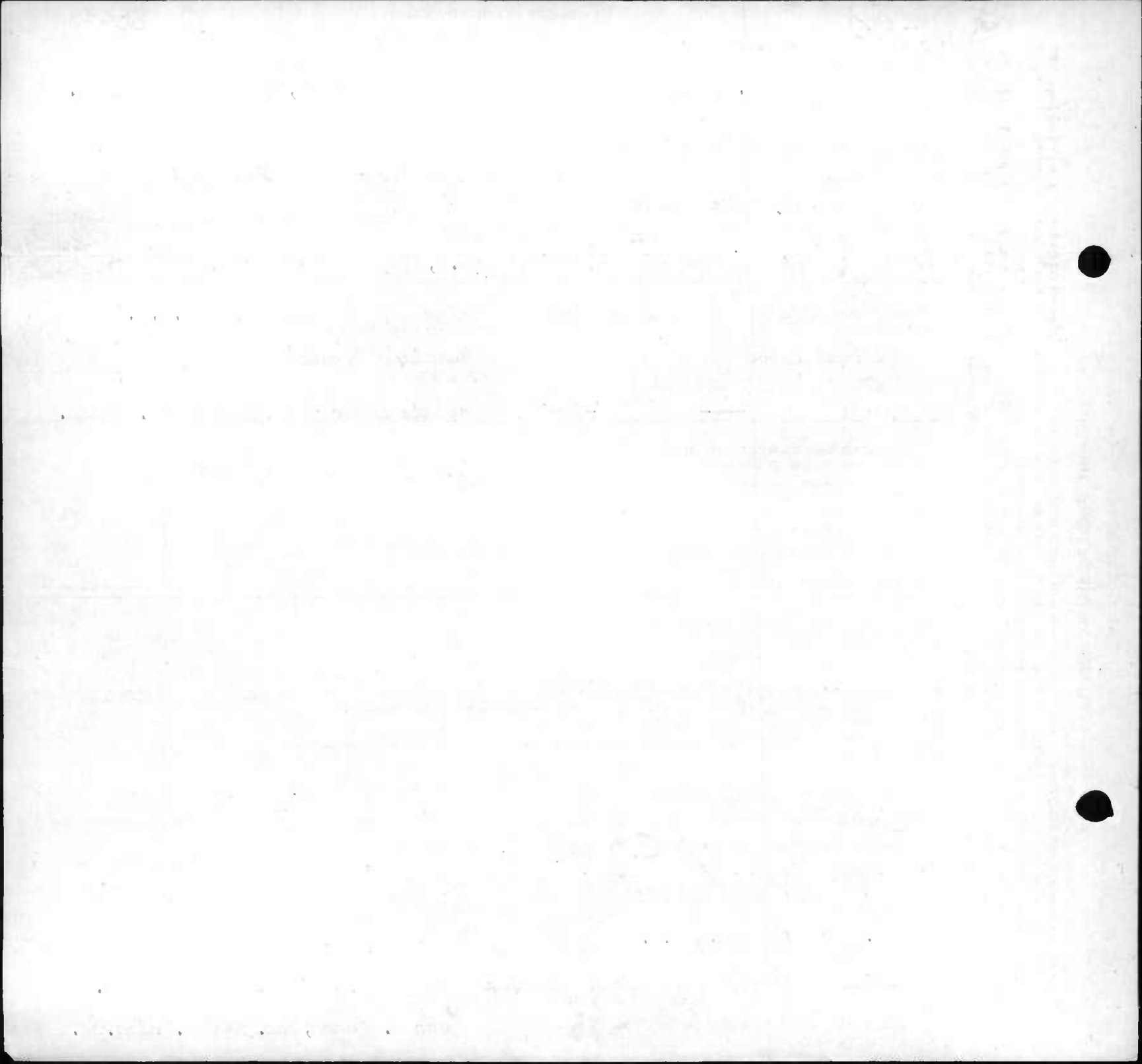
W-623 70 6523		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6523	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WRIGHT, VIRGINIA LEE		JUNE 24, 1970 4:20 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		MARYLAND		C. CITY OR TOWN BALTIMORE	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3408 AVONDALE AVENUE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07 25 25	9. AGE On years last birthday 44	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY HOCHSCHILD KOHN		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME GILBERT CAVEY		14. MOTHER'S MAIDEN NAME LOUISE OVERWETTER		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ST AGNES HOSP RECORDS-BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: Papillary adenocarcinoma of ovary with multiple metastases (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 22 19 70 to JUNE 24 19 70 that (X) (we) last saw the deceased alive on JUNE 24 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Aurora A. Payabyab		23B. DATE SIGNED 6-24-70		23C. PHYSICIAN'S NAME (Type) AURORA A PAYABYAB	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-1970		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Hubbard Funeral Home Inc. 4107 Wilkens Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

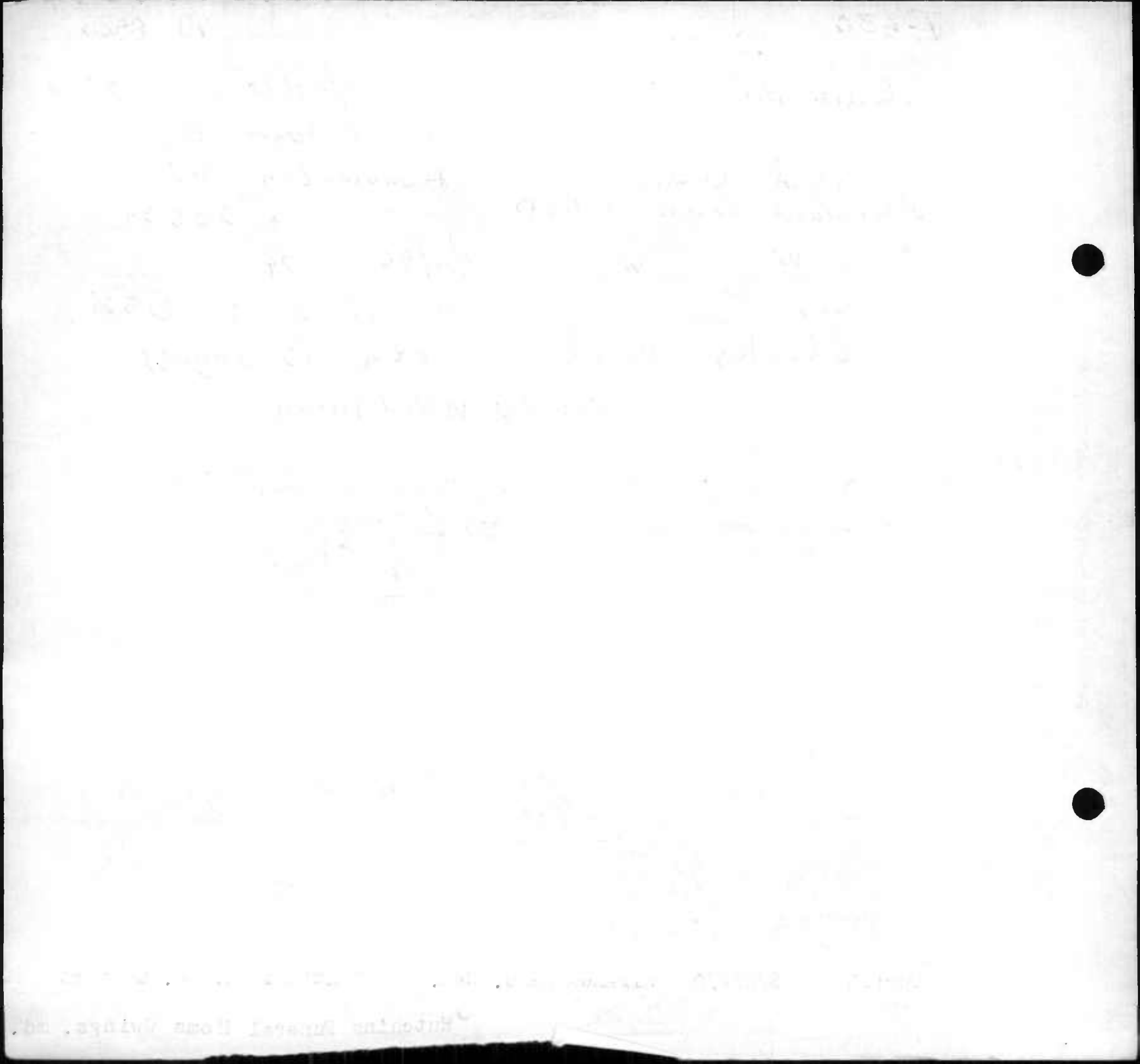
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6524</u>	
L-100		70 6524		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Roy J. Labbe</u>			2. DATE AND HOUR OF DEATH <u>June 25, 1970</u> <u>11 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 548 Wyanoke Avenue</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>901</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>548 Wyanoke Avenue</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1903</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>self employed</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Coin machine</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>	
13. FATHER'S NAME <u>Gilbert Labbe</u>			14. MOTHER'S MAIDEN NAME <u>Mathilda Rosseau</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>276-12-6850</u>		17. INFORMANT <u>Roberta Labbe 548 Wyanoke Ave. Balto.</u>	
18. <u>403X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 26 1969</u> to <u>JUNE 25 1970</u> , that (I) (we) last saw the deceased alive on <u>June 17 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>W. M. Smith</u> DEGREE 23B. DATE SIGNED <u>6/24/70</u> 23C. PHYSICIAN'S NAME (Type) <u>W. Meredith Smith, M.D.</u> DEGREE 23D. ADDRESS <u>6305 The Alameda</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>6/29/70</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u> 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u> 25B. NAME OF REGISTRAR <u>Robert E. Taber, R.D.</u> 25C. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Balto. St.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

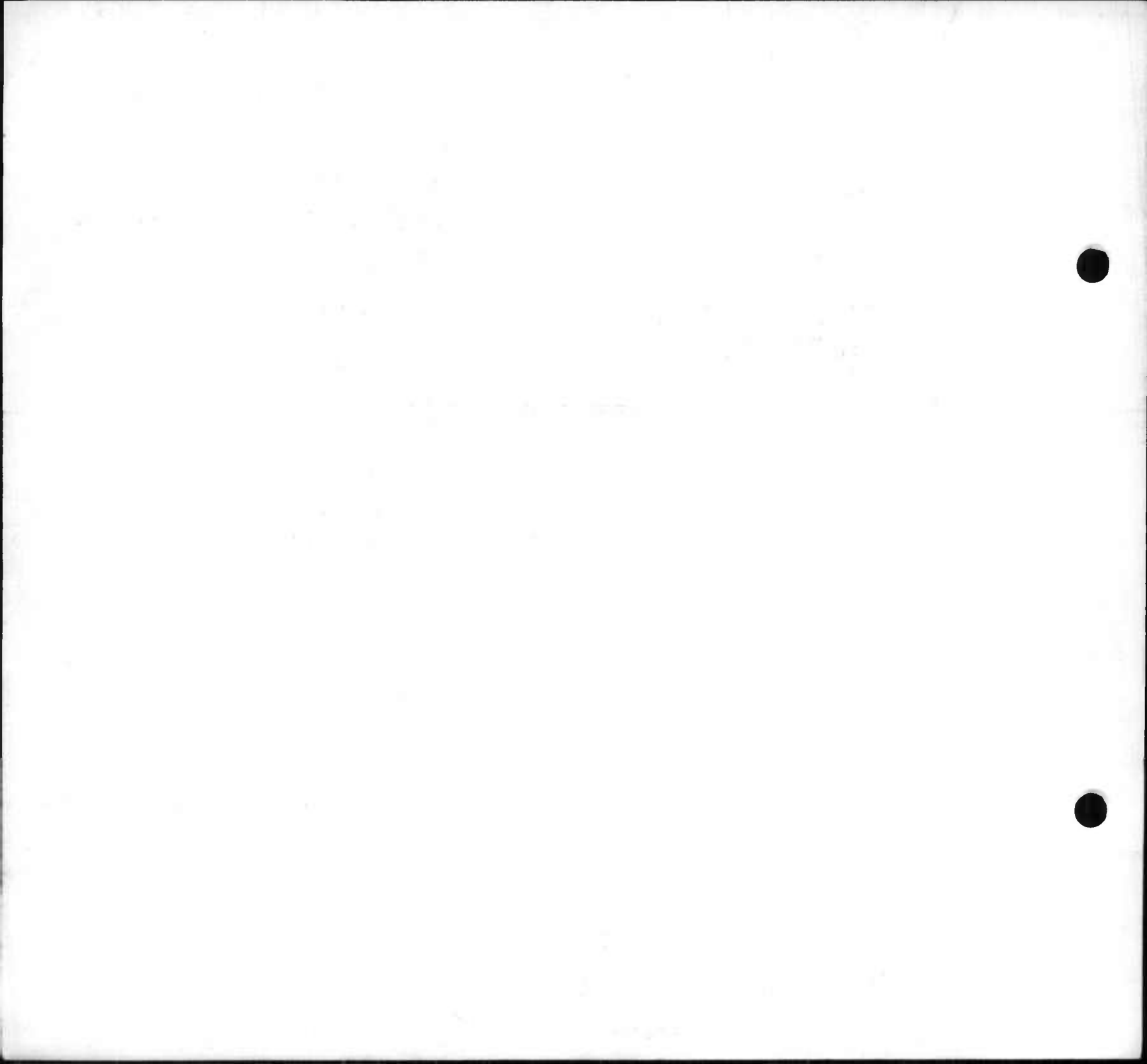
T-630 BIRTH NO. 70 6525		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 70 6525	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Edith W. Trott		2. DATE AND HOUR OF DEATH 6/24/70 9⁵⁰ A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md. Gen. Maryland General Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Calvert Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Huntingtown Md. D. STREET ADDRESS (If rural, give location) Zip 20639			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W	8. DATE OF BIRTH 1/11/96	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland-D.C.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Ward		14. MOTHER'S MAIDEN NAME Etta Burgess	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-62-8637		17. INFORMANT Mildred Brown ADDRESS	
18. 5-9-21-X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO Gram neg. Septicemia Acute Pyelonephritis (B) Septicemia (C) Kidney Stones		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 1/6/22		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal Stones		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/19/70 19 to 6/24/70 19 that (I) (we) last saw the deceased alive on 6/24/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dewitt E. Kemp M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 6/24	
23C. PHYSICIAN'S NAME (Type) Dewitt Kemp M.D.				23D. ADDRESS 3206 Kelox Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/70		24C. NAME OF CEMETERY OR CREMATORY Mirania memo. Cem.	
24D. LOCATION (City, town, or county) (State) Huntingtown, Md. Calvert		25A. DATE RECEIVED BY HEALTH DEPT. JUN 29 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. FUNERAL DIRECTOR ADDRESS Hutchins Funeral Home Owings, md.			



FUNERAL DIRECTOR: IMPORTANT

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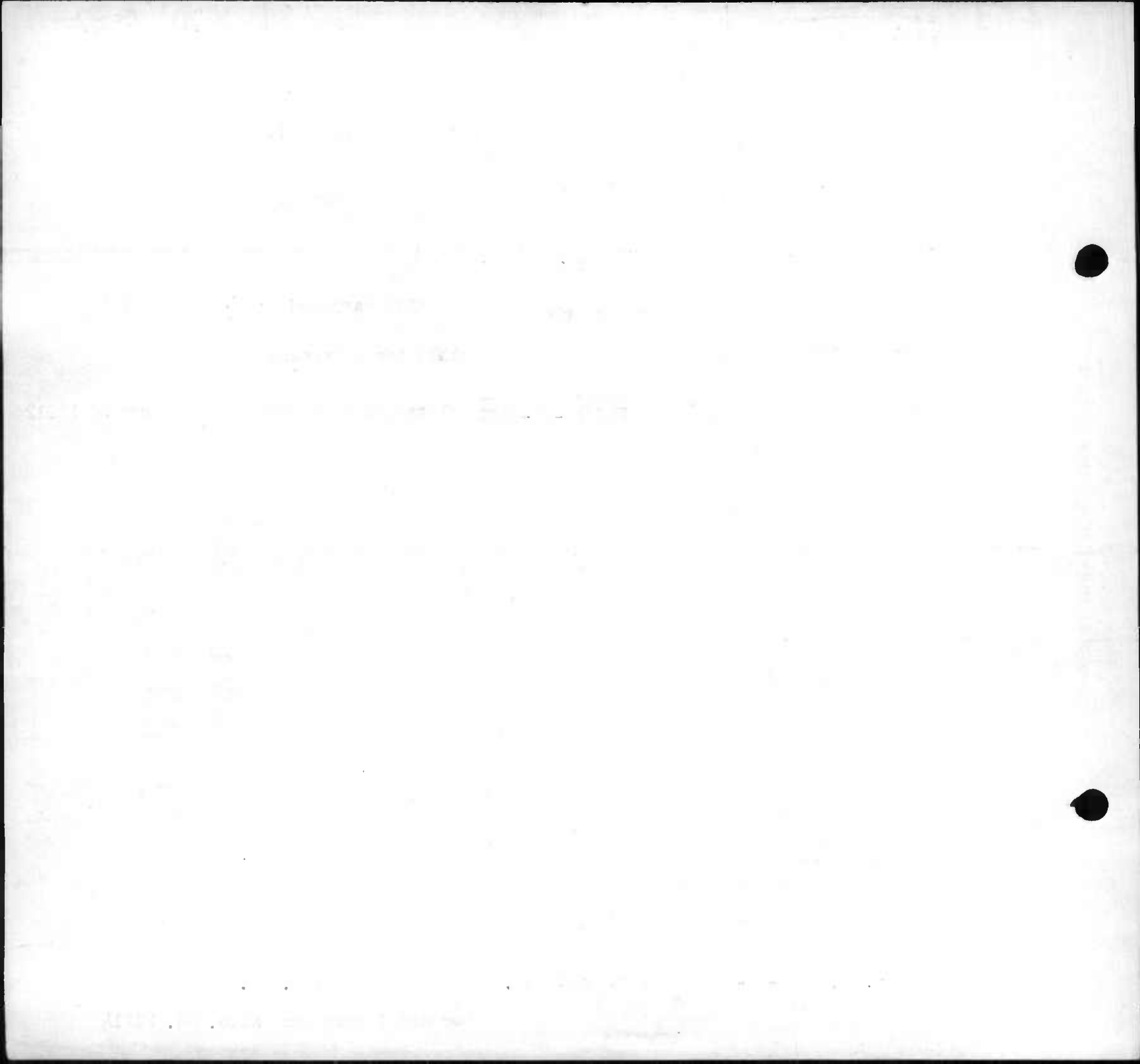
B-530		70 6526		BALTIMORE CITY HEALTH DEPARTMENT		70 6526	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) MARY F BENNETT				2. DATE AND HOUR OF DEATH 6-25-1970 11:32 P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Church Home Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2788			
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 1-17-06		9. AGE (in years last birthday) 64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady				10B. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Jones				14. MOTHER'S MAIDEN NAME Frances Shinsky			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No				16. SOCIAL SECURITY NO. 214305994		17. INFORMANT Self ADDRESS	
18. 182.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE Endometrial Carcinoma DUE TO, OR AS A CONSEQUENCE OF: pulmonary emboli.			
				(B) Endometrial Carcinoma DUE TO, OR AS A CONSEQUENCE OF:			
MEDICAL CERTIFICATION				19A. DATE OF OPERATION 6-25-70			
				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no			
20A. AUTOPSY? (Yes or No) no				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED			
21F. HOW DID INJURY OCCUR?				21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22. I certify that (I) (this hospital) attended the deceased from 6-9-70 to 6/25-70 and that (I) (we) last saw the deceased alive on 6/25-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Pisano				23B. DATE SIGNED 6-25-70			
23C. PHYSICIAN'S NAME (Type) R. Pisano				23D. ADDRESS /Loring Byers 8728 Liberty Road 21133			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6/29/70			
24C. NAME of CEMETERY or CREMATORY Lake View Memorial Park				24D. LOCATION Sykesville Carroll Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970				25B. NAME OF REGISTRAR Robert E. Taber, M.D.			
25C. FUNERAL DIRECTOR				25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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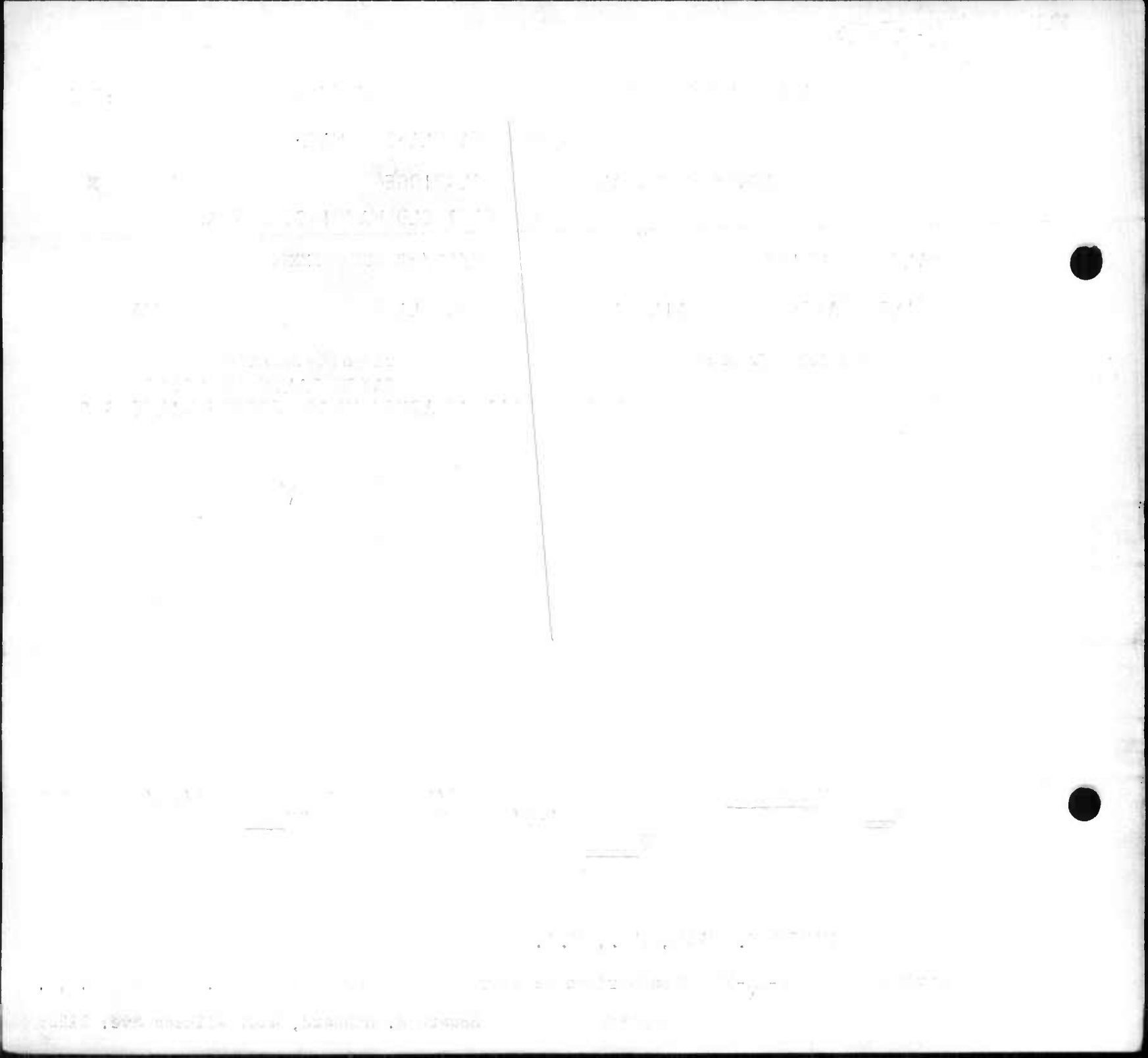
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 70 6527	
BIRTH NO. 5-140 70 6527		CERTIFICATE OF DEATH			
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LEROY B. SHIPLEY		2. DATE AND HOUR OF DEATH 6/25/1970 5.55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GEN. HOSPITAL.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY City of Baltimore. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE. D. STREET ADDRESS (If rural, give location) 1026 Reveryd Road.			
5. SEX Male.	6. RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/31/1908.	9. AGE (In years last birthday) 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk.		10B. KIND OF BUSINESS OR INDUSTRY Western Electric		11. BIRTHPLACE (State or foreign country) XXXX Maryland	12. CITIZEN OF WHAT COUNTRY? USA XXXX.
13. FATHER'S NAME Guy Shipley.			14. MOTHER'S MAIDEN NAME XXXX Ida E Magness		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. XXXX-XX-XXXX		17. INFORMANT ADDRESS Elizabeth T Shipley 1026 Reveryd Rd 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Metastasized Bronchogenic Carcinoma INTERVAL BETWEEN ONSET AND DEATH 18 months					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/18/1970 to 6/25/1970, that (I) (we) last saw the deceased alive on 6/24/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Al- Ibrahim.				23B. DATE SIGNED 6/25/1970.	
23C. PHYSICIAN'S NAME (Type) MOHAMMED S. AL-IBRAHIM M.D.				23D. ADDRESS MD. Gen. Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-70		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970			
25B. NAME OF REGISTRAR Robert E. Taylor R.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Rueck Inc Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

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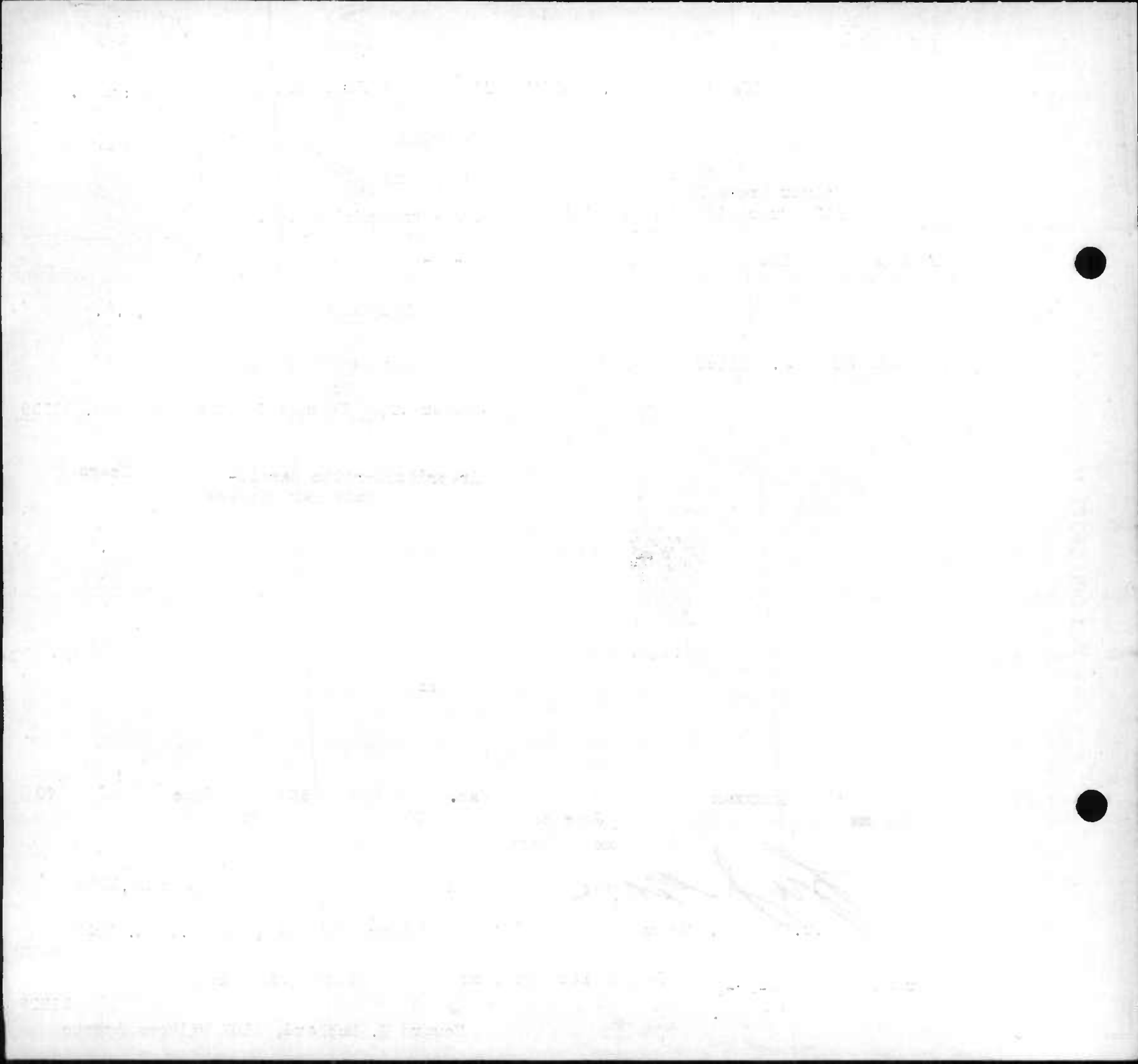
MLM 1		BALTIMORE CITY HEALTH DEPARTMENT		X	
L-550		70 6528		CERTIFICATE OF DEATH	
BIRTH NO.		70 6528		REG. NO. 70 6528	
1. NAME OF DECEASED (Type or Print) LANAHAN, LUKE JOHN			2. DATE AND HOUR OF DEATH 6/26/70 8:30A		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN ELKBRIDGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6101 OLD WASHINGTON ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/89 88	9. AGE (In years last birthday) 80 81	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILER MAKER		10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Dominick Lanahan		
14. MOTHER'S MAIDEN NAME Bridge Scharin			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 705 05 2111			17. INFORMANT CATON BALTO MD 21229 ST AGNES HOSP RECORDS WILKENS &		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute MI ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCUD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 6/18 1970 to 6/26/ 19 70 that (X) (we) last saw the deceased alive on 6/26/ 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Haven N. Wall, Jr., M.D.			23B. DATE SIGNED 6-26-70		23C. PHYSICIAN'S NAME (Type) HAVEN N. WALL, JR., M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 6-30-70		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery
24D. LOCATION (City, town, or county) (State) Washington Blvd., Howard Co. Md.			25A. DATE FACED BY HEALTH DEPT. JUN 29 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.			25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

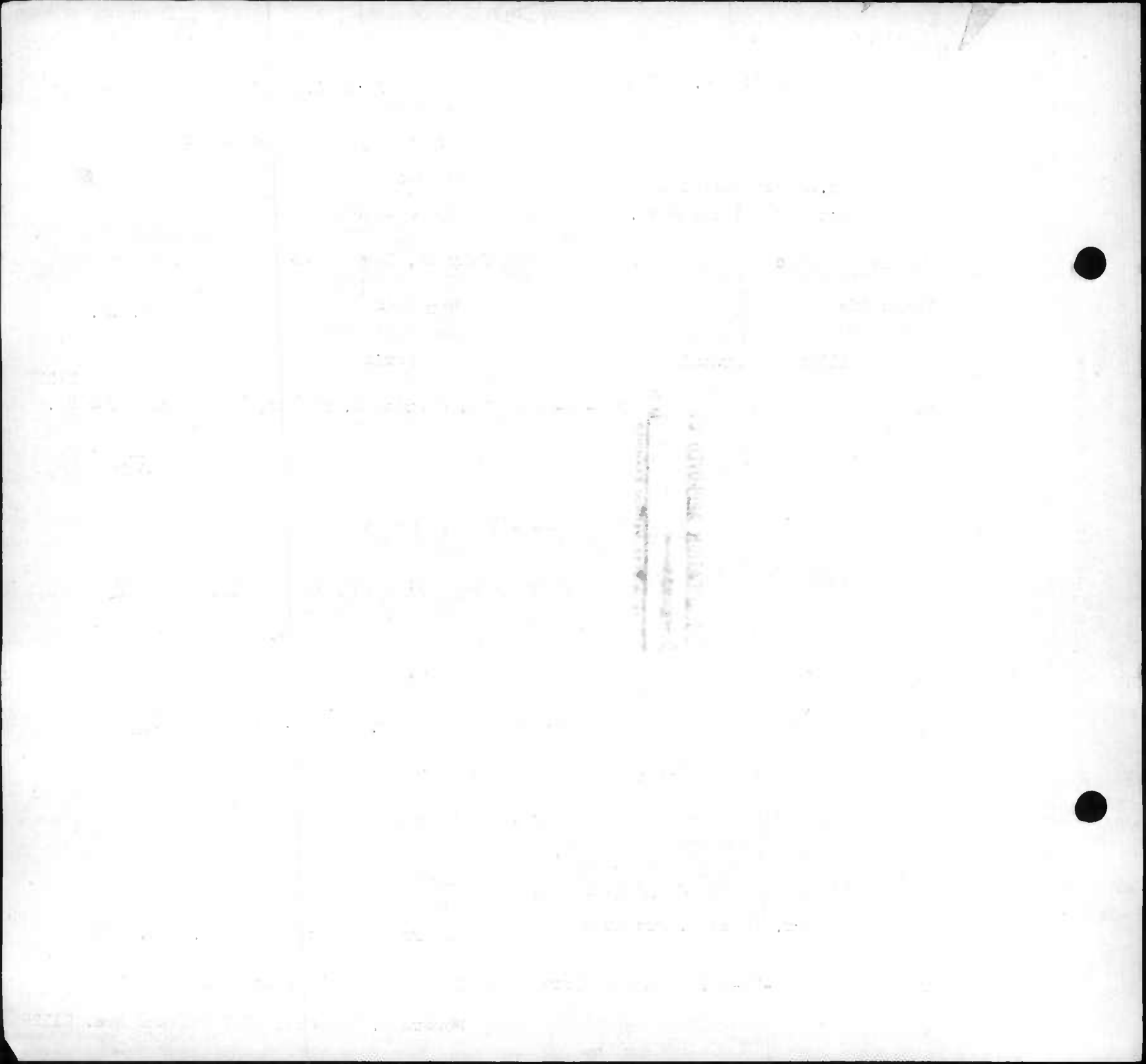
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6529	
<p>P-632 70 6529</p> <p>BIRTH NO.</p>		<p>CERTIFICATE OF DEATH</p>			
<p>1. NAME OF DECEASED (Type or Print) FLORENCE H. PRITCHETT</p>			<p>2. DATE AND HOUR OF DEATH June 25, 1970 10:30 P. M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2854</p>		
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 Silver Cross Home 5124 Greenwich Avenue 21229</p>			<p>C. CITY OR TOWN Baltimore</p>		<p>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p>
<p>5. SEX Female</p>			<p>6. RACE White</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 8-16-1869</p>
<p>9. AGE (In years last birthday) 100</p>			<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>			<p>13. FATHER'S NAME Richard A. Miller</p>		
<p>14. MOTHER'S MAIDEN NAME Sophia Waller</p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		
<p>16. SOCIAL SECURITY NO.</p>			<p>17. INFORMANT ADDRESS Silver Cross Home, 5124 Greenwich Ave. 21229</p>		
<p>18. CAUSE OF DEATH</p>					
<p>412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardio-Vascular Disease</p>					
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) no</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (not named) attended the deceased from Jan. 19 65 to June 19 70, that (I) was lost saw the deceased alive on June 23 19 70 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.</p>					
<p>23A. SIGNATURE [Signature] Dr. Leo J. Gaver</p>				<p>23B. DATE SIGNED June 26, 1970</p>	
<p>23C. PHYSICIAN'S NAME (Type) Dr. Leo J. Gaver</p>				<p>23D. ADDRESS 1 Mallow Hill Road, Balto., Md. 21229</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 6-30-70</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery</p>	
<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>		<p>25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970</p>			
<p>25B. NAME OF REGISTRAR Robert E. Taylor, Jr.</p>		<p>25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue</p>			



FUNERAL DIRECTOR: IMPORTANT

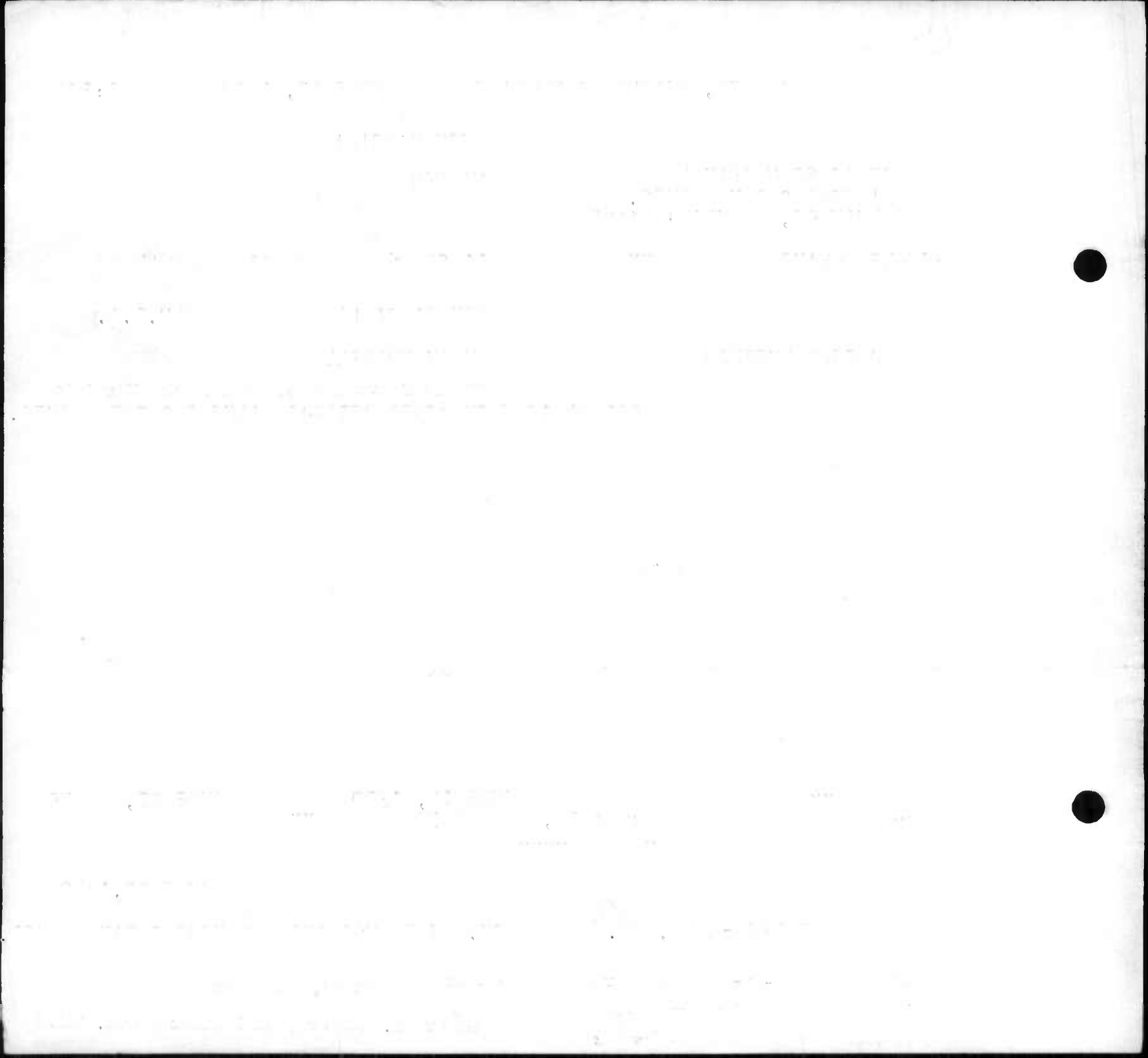
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>70 6530</u>	
<div style="display: flex; justify-content: space-between;"> M-460 70 6530 </div>				<div style="display: flex; justify-content: space-between;"> 70 6530 70 6530 </div>			
BIRTH NO. <u>1</u>				1. NAME OF DECEASED (Type or Print) BESSIE O. MILLER			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40</u> St. Agnes Hospital Caton & Wilkens Aves.				2. DATE AND HOUR OF DEATH June 25, 1970 <u>210 P.</u> M.			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore				C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 5100 Shelbourne Road							
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1884	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Carneal			14. MOTHER'S MAIDEN NAME Maria				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-54-7549		17. INFORMANT ADDRESS 21227 Mr. Charles A. Miller, 5100 Shelbourne Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease or condition which caused death.) 250.9 + 288.9 Acute Pulmonary Edema (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A-S CVD (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus - Controlled Fracture left hip Fracture left shoulder			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which preceded or contributed to the above cause (A) UNDERLYING CONDITION lost. II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE OR CONDITION GIVEN IN PART I.							
19A. DATE OF OPERATION 6-18-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURES		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5100 SHELBOURNE RD			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 6-17-70 2PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? FELL AT HOME			
22. I certify that (I) (this hospital) attended the deceased from <u>July 1970</u> to <u>6/25</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>6/25</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James N. Frederick				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/26/70	
23C. PHYSICIAN'S NAME (Type) Dr. James N. Frederick				23D. ADDRESS 1311 Francis Avenue, Balto., Md. 21227			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-1970		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21229	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

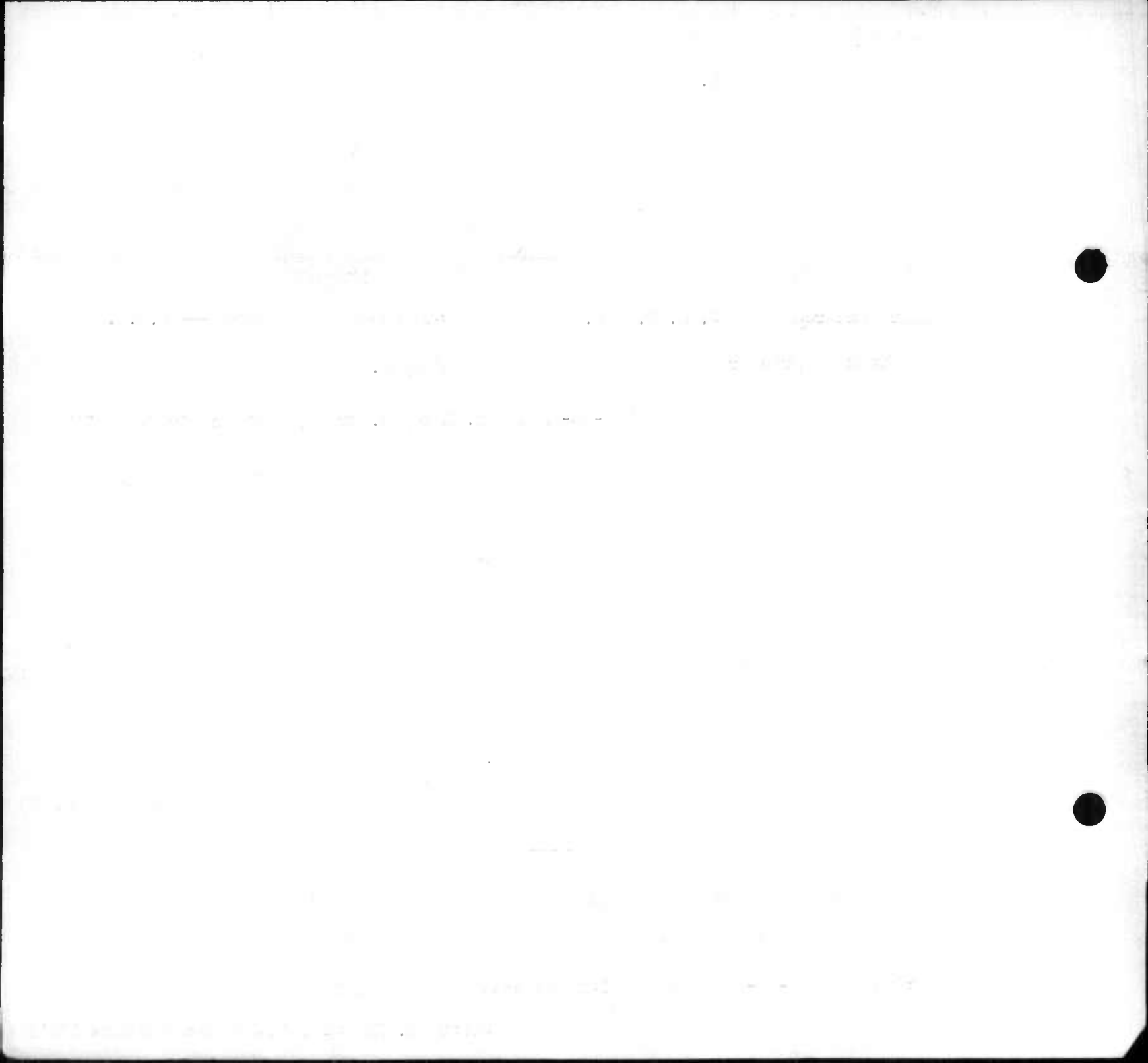
C-160		70 6531		BALTIMORE CITY HEALTH DEPARTMENT		70 6531	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
COOPER, BERTHA CATHERINE				JUNE 27, 1970 1:35A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
ST AGNES HOSPITAL 40 WILKENS & CATON AVES. BALTIMORE, MARYLAND 21227				WEST VIRGINIA V-45			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11 09 86	
9. AGE (In years last birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
83						WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
U.S.A.		JOSEPH HUFFMAN		MARY MORRELL			
16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
232 64 1598		Hinkle Funeral Home, Davis, West Virginia		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
		ST AGNES RECORDS WILKENS & CATON AVES.		(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
				ANTECEDENT CAUSES			
				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
				II			
				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from JUNE 17, 1970 to JUNE 27, 1970 that (X) (we) last saw the deceased alive on JUNE 27, 1970 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Zaheer-Kahn				JUNE 27, 1970			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
ZAHEER-KAHN, MD.				ST. AGNES HOSPITAL WILKENS & CATON AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		6-30-1970		Cooper Family Cemetery		Harman, West Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 29 1970		Robert E. Taylor, MD.		Howard H. Hubbard		4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

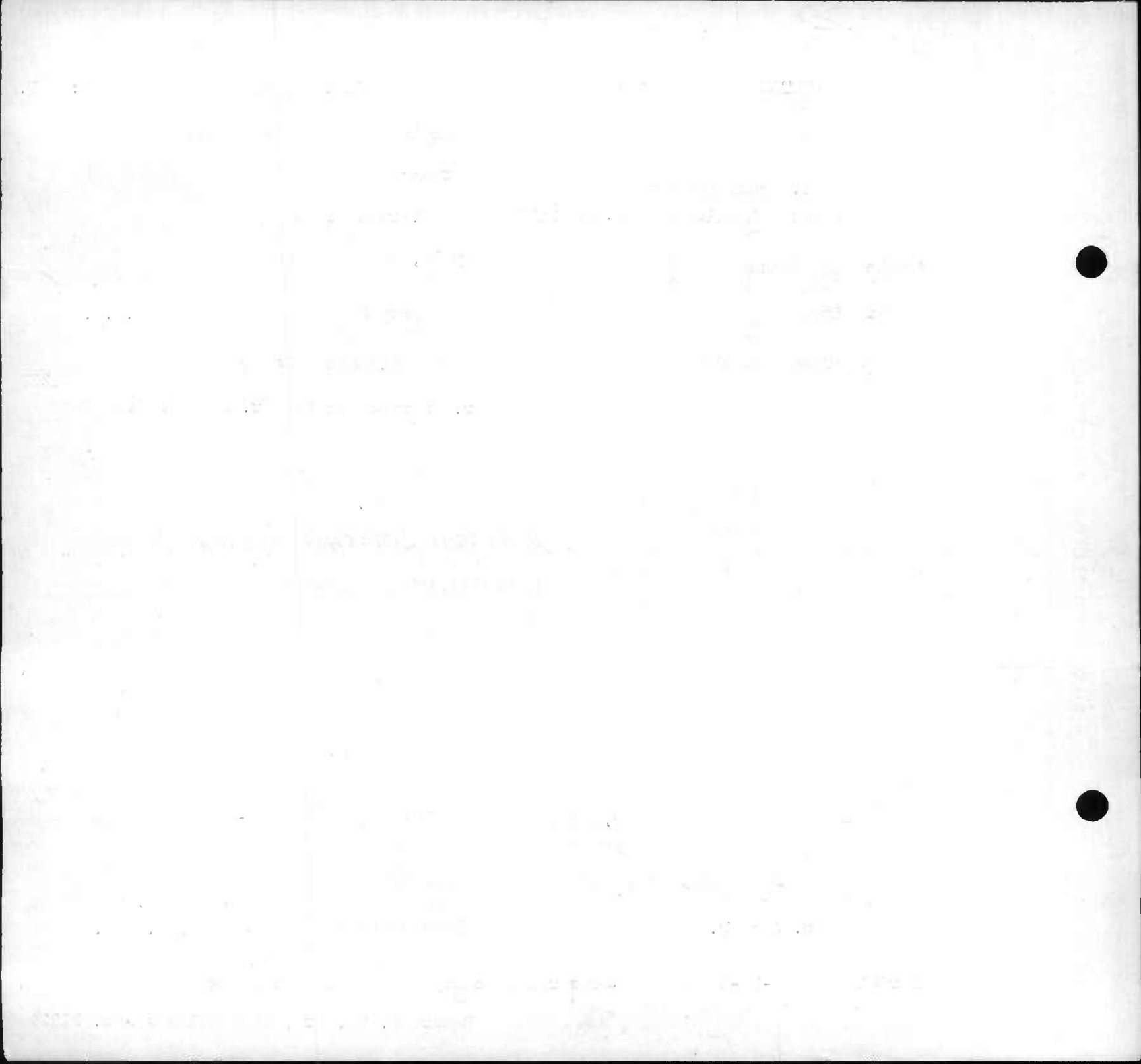
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6532</u>	
K-626 70 6532				CERTIFICATE OF DEATH	
BIRTH NO. <u>1</u>		1. NAME OF DECEASED (Type or Print) <u>MILDRED A. KRIEGER</u>		2. DATE AND HOUR OF DEATH <u>June 24 11:25 P.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MONTEBELLO STATE HOSP</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2006</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>522 PARKSLEY AVE</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-06</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U. S. F. & G.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Frank Krieger</u>		
14. MOTHER'S MAIDEN NAME <u>Lilly A.</u>			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-10-9531</u>			17. INFORMANT ADDRESS <u>Mr. LeRoy C. Groll, 5447 Belair Road 21206</u>		
18. CAUSE OF DEATH <u>1519 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Adenocarcinoma of the stomach & metastasis to liver</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Anemia</u>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>5</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 24 1970</u> to <u>JUNE 24 1970</u> that (I) (we) last saw the deceased alive on <u>June 24 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Dayatullah</u>			23B. DATE SIGNED <u>6-24-70</u>		23C. PHYSICIAN'S NAME (Type) <u>M. DAYATULLAH</u>
23D. ADDRESS <u>MONTEBELLO STATE HOSP</u>			24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>6-29-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE RECEIVED BY HEALTH DEPT. <u>JUN 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Huber</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>	
ADDRESS <u>4107 Wilkens Avenue 21229</u>					



FUNERAL DIRECTOR: IMPORTANT

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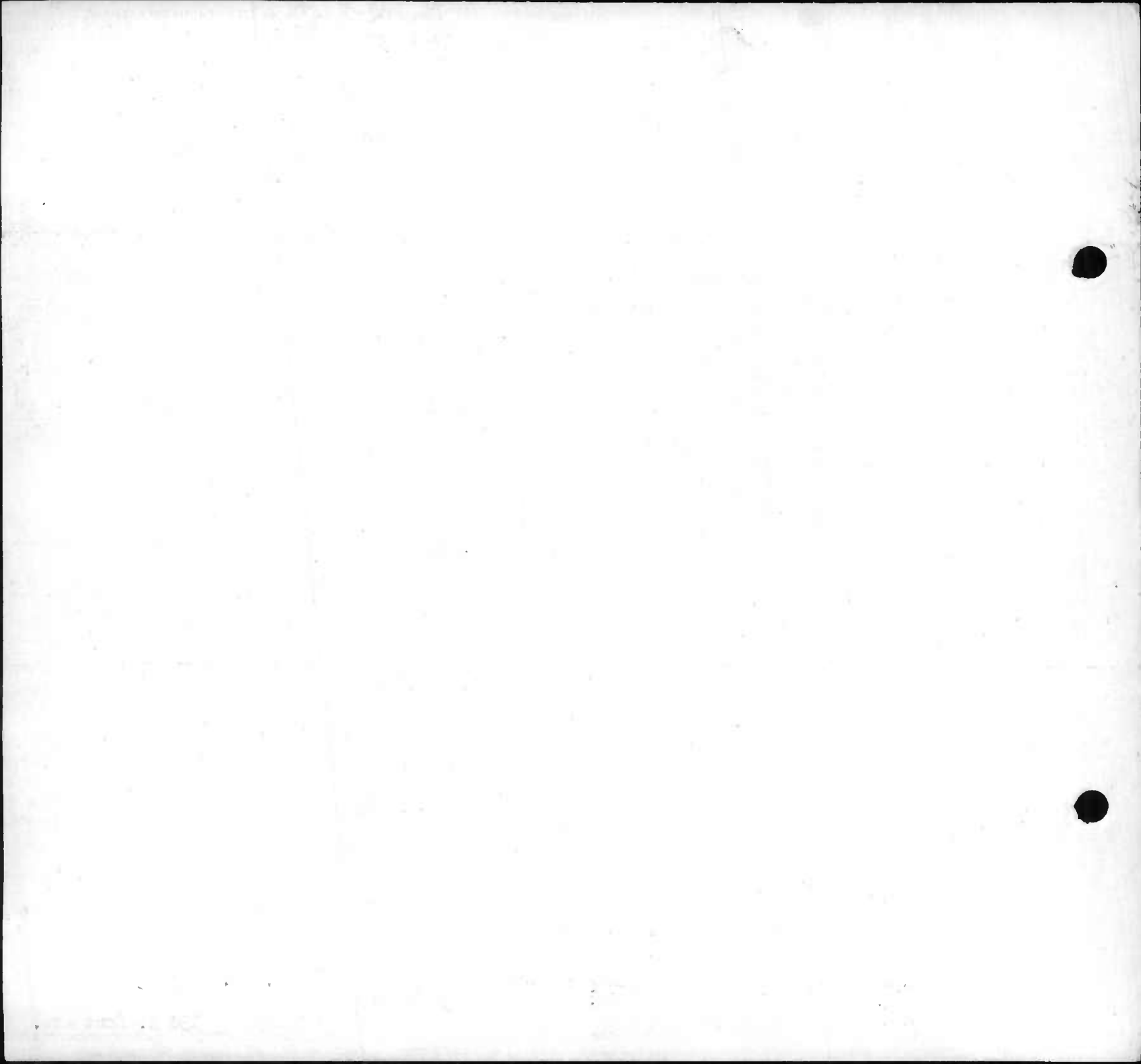
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6533	
G-655 70 6533		BIRTH NO.		70 6533	
1. NAME OF DECEASED (Type or Print) MYRTLE MAE GORMAN			2. DATE AND HOUR OF DEATH June 24, 1970 12:55 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital Caton & Wilkens Avenues 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 934 Circle Drive		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1898	9. AGE (In years lost birth day) 72	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Cauffman		14. MOTHER'S MAIDEN NAME Elizabeth Lamar	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 21227 Mr. Maurice Gorman, Jr. 5733 Oakland Road	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: P.P. USE MYOCARDIAL INFARCTION (B) DISEASE OR CONDITION, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. DISEASE OR CONDITION GIVING RISE TO THE ABOVE CAUSE (A) stating the UNDERLYING CONDITION lost. (C) VASCULAR HEMORRHAGE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1 1957 to 6/24 1970, that (I) (we) lost saw the deceased alive on 6/24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] DEGREE				23B. DATE SIGNED 6/26/70	
23C. PHYSICIAN'S NAME (Type) Dr. John H. Shaw				23D. ADDRESS 5800 Edmondson Avenue, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-27-1970		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUN 29 1970		24F. NAME OF REGISTRAR [Signature]	
24G. FUNERAL DIRECTOR		24H. ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

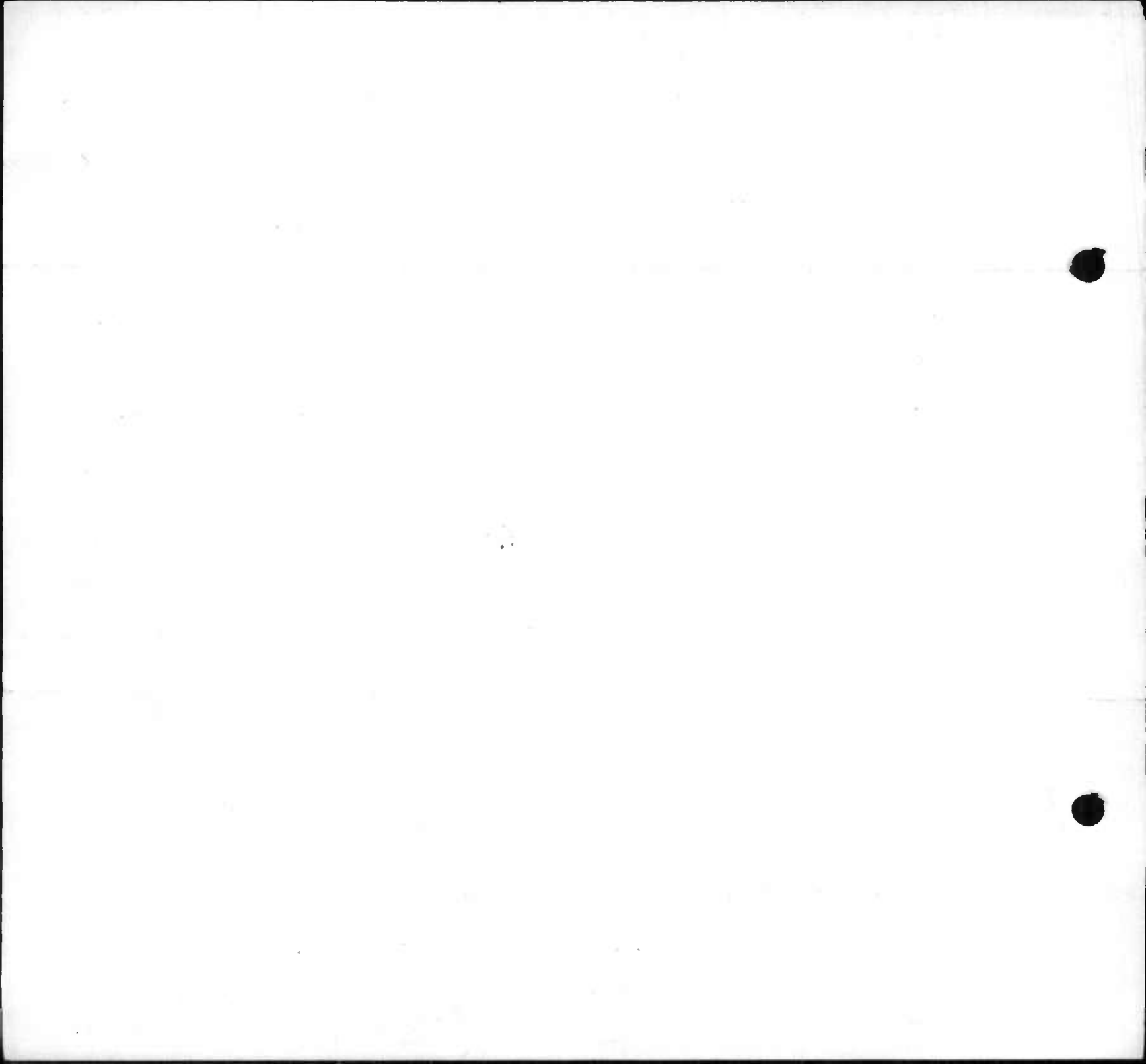
BIRTH NO. <u>D-120</u> <u>70</u> <u>6534</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70</u> <u>6534</u>	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <u>Davis Albert D. Sr.</u>				2. DATE AND HOUR OF DEATH <u>6-26-70</u> <u>12.30</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>S.B.G.H.</u>				A. STATE <u>Maryland</u> B. COUNTY <u>2404</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1606 Johnson St. Baltimore</u>			
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-22-1898</u>	9. AGE (In years lost birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Balt. & Ohio R.R.)</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Machinist</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>John K. (Dec.)</u>				14. MOTHER'S MAIDEN NAME <u>Nora Moxley (Dec.)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>	
18. <u>41241</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>AS.</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CONGESTIVE HEART FAILURE</u> <u>A.S.C.V.D.</u> (B) <u>BRONCHOPNEUMONIA</u> , <u>BLADDER INFECTION</u> DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-25</u> 19 <u>70</u> to <u>6-26</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>6/26/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Nabil Yacoub Younan M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>NABIL YACOB YOUNAN M.D.</u>				23D. ADDRESS <u>South Baltimore General Hosp</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6 29 70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mc Cully</u>		ADDRESS <u>130 E. Fort Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

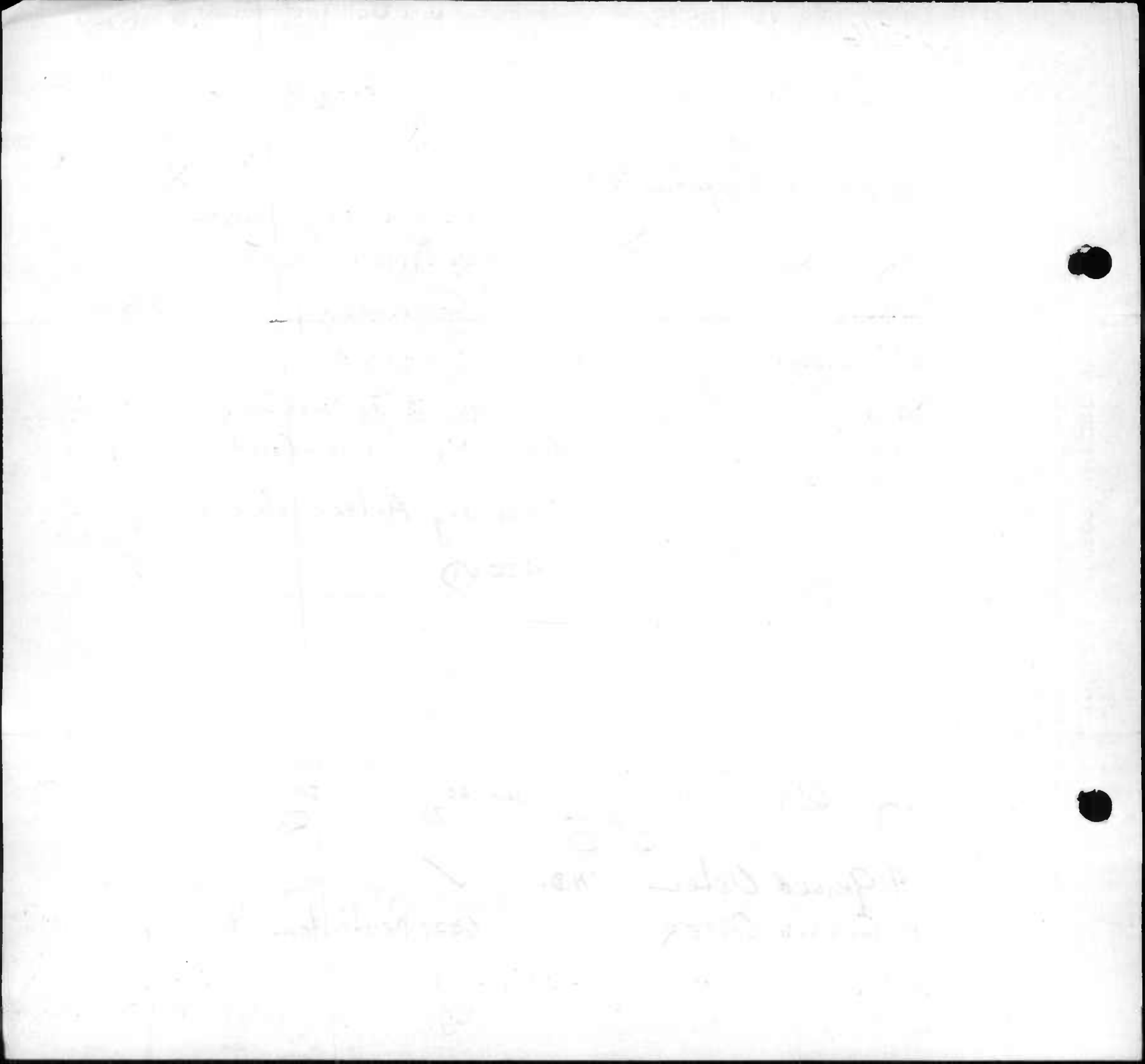
T-200		70 6535		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6535	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MARGARET E. THEISS			
2. DATE AND HOUR OF DEATH June 25, 1970 7:30 A. M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3452 Erdman Ave.			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland				B. CITY OR TOWN Baltimore			
C. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				D. STREET AND NUMBER 3452 Erdman Ave.			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 24, 1872	
9. AGE (In years last birthday) 97		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME John Fresch				14. MOTHER'S MAIDEN NAME Marie Prag			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. 218-52-1343		17. INFORMANT ADDRESS Miss Marie Theiss, 3452 Erdman Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive heart failure, recurrent (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) Pulmonary Congestions Anemia & mild diabetes			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years months months & years							
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II 19A. DATE OF OPERATION 6/24/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21A. TIME OF INJURY (Month) (Day) (Year) (Hour) 21B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21C. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from Feb 19 57 to 6/25 19 70 and that (I) (we) last saw the deceased alive on 6/24 19 70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Samuel Morrison				23B. DATE SIGNED 6/26/70		23C. PHYSICIAN'S NAME (Type) Samuel Morrison, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6/29/70		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.				25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. J. Jr., Md.	
25C. FUNERAL DIRECTOR Ulrich Funeral Home, 4210 Belair Road.				25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

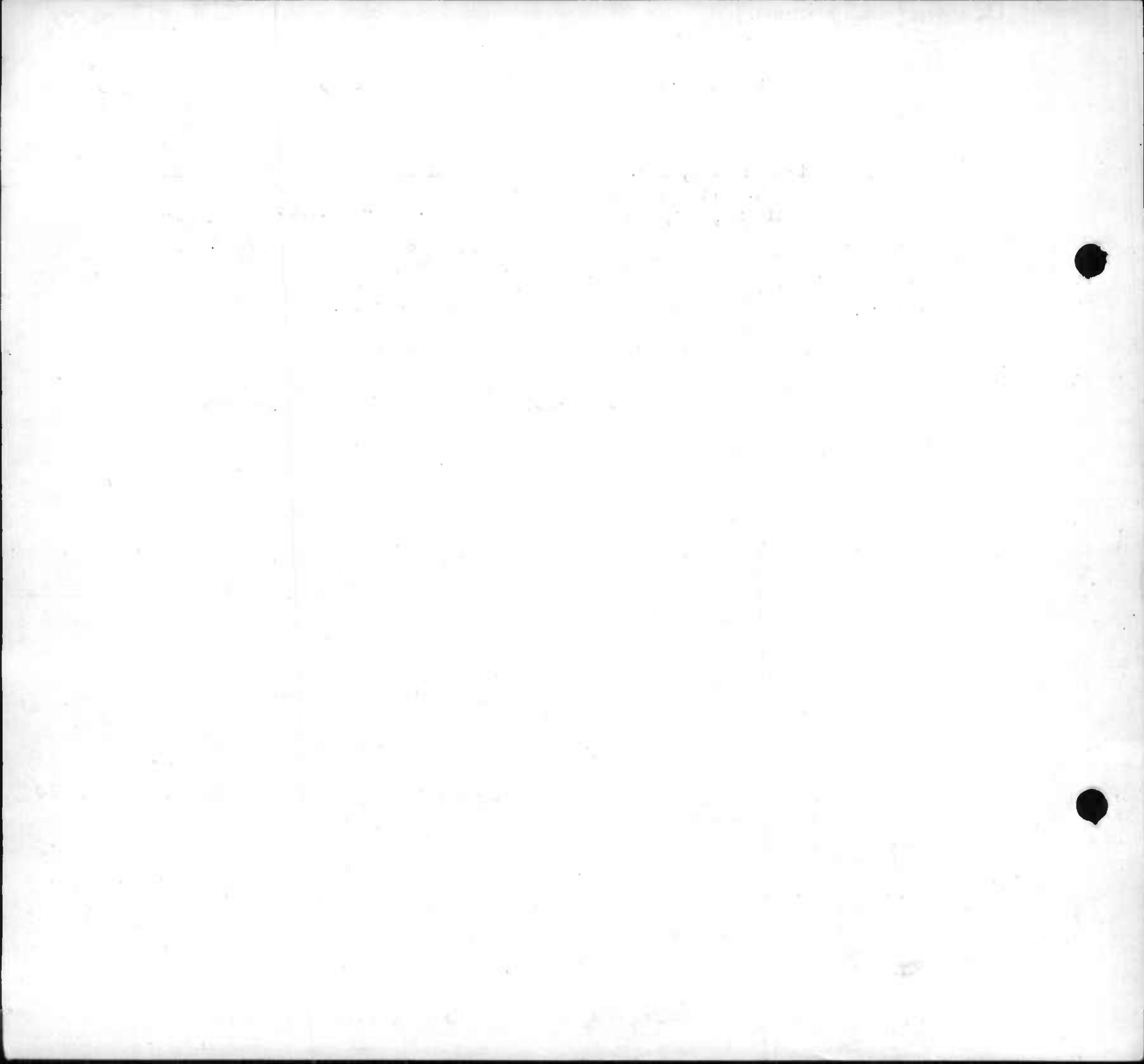
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6536	
<div style="display: flex; justify-content: space-between;"> W-516 70 6536 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
1. NAME OF DECEASED (Type or Print) Leopold Weinberg		2. DATE AND HOUR OF DEATH 6-26-70 5:45 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 003312 W. Rogers Ave		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 2719 C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3312 W. Rogers Ave			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1904		9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J. S. S. S.		14. MOTHER'S MAIDEN NAME Regina	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Berta Weinberg	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		CAUSE OF DEATH Acute Myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) ?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instantaneous 5 years or more	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Jan 20 19 70 to 6-26 19 70 , that (1) (we) last saw the deceased alive on 6-26 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. Gerald Oster M.D. DEGREE				23B. DATE SIGNED 6/26/70	
23C. PHYSICIAN'S NAME (Type) H. GERALD OSTER				23D. ADDRESS 6821 Reisterstown Road Balto Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/70		24C. NAME OF CEMETERY or CREMATORY Chesa-chaves Chapel	
24D. LOCATION (City, town, or county) Randallstown		24E. STATE Md		24F. FUNERAL DIRECTOR'S ADDRESS Sylvan Lewis & Son 9610 Reisterstown Rd	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. SIGNATURE OF REGISTRAR Sylvan Lewis & Son	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

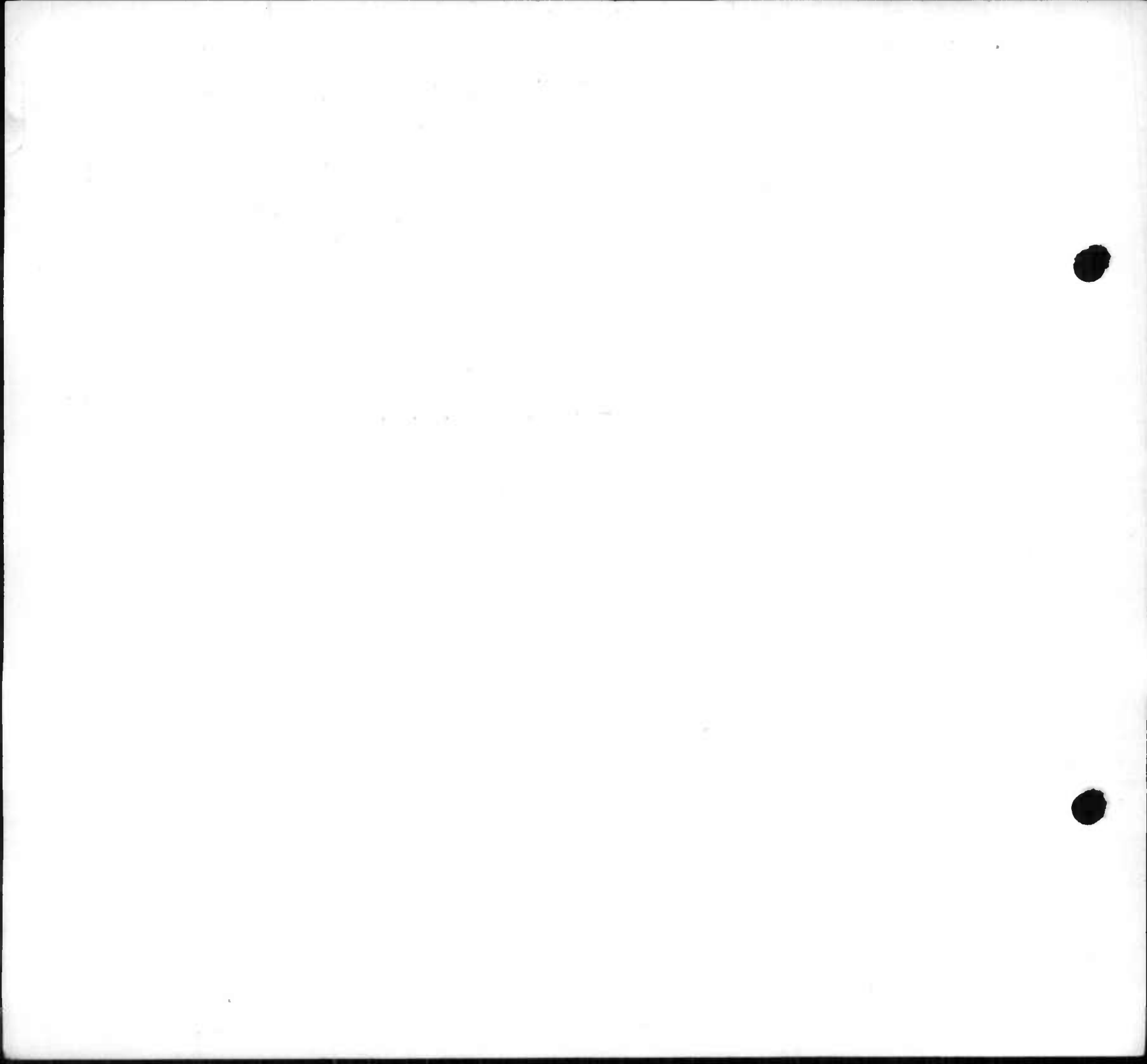
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
A-252 70 6537		70 6537		70 6537	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joseph M. ASKINS		6/25/70 3:50 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202		A. STATE Md		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		C. CITY OR TOWN Baltimore			
		E. STREET AND NUMBER 600 E. Eager Street			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/7/22	9. AGE (In years last birthday) 47	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer		Constr.		Florence, S.C.	
13. FATHER'S NAME Freddie Askins		14. MOTHER'S MAIDEN NAME Dise Grant		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 251-26-9537		17. INFORMANT ADDRESS Annie McNeil 600 E. Eager St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH UREMIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MASSIVE Gastrointestinal Hemorrhage (B) Hypertension DUE TO, OR AS A CONSEQUENCE OF: Chronic Renal Disease (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/27 1970 to 6/25 1970, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE William D. Appleberry				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) William D. Appleberry				23D. ADDRESS 6615 Reisterstown Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. ADAMS Marshall W. Jones, Jr.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

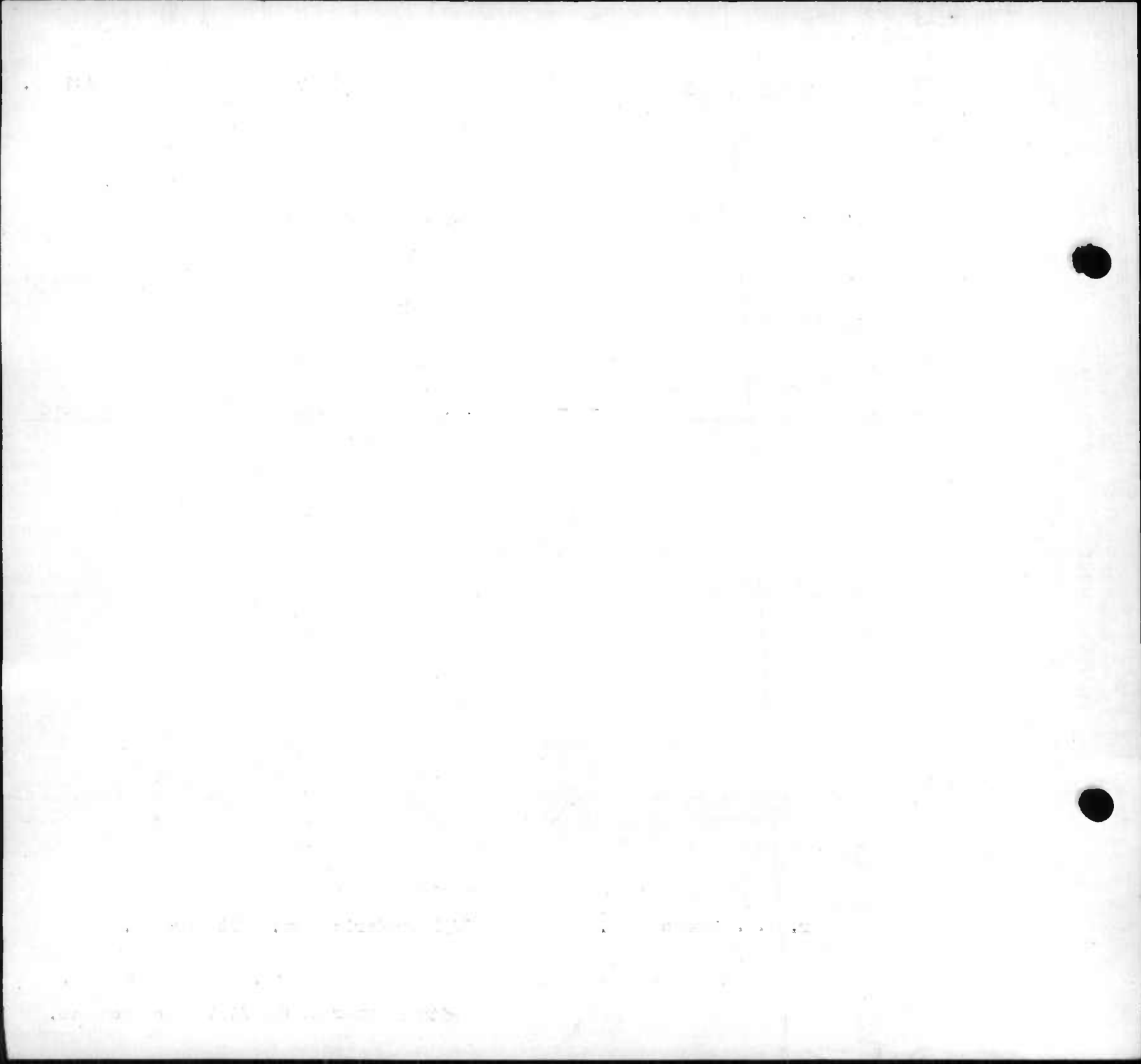
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6538</u>	
L-526 70 6538				CERTIFICATE OF DEATH	
BIRTH NO. <u>1526</u>		1. NAME OF DECEASED (Type or Print) <u>MRS. ISABELLE M. LANGRALL</u> (Isabel H. Langrall)			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>6/27/70 (6/27/70) 5:30 AM</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secour Hospital</u> <u>Bon Secours Hosp</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u> <u>Baltimore</u> <u>2854</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>416 N. Chapel Gate Lane</u>			
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/5/98</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u> <u>New Jersey</u>	
13. FATHER'S NAME <u>Edwin Moore</u> <u>Edwin Moore</u>		14. MOTHER'S MAIDEN NAME <u>Elvira Carter</u> <u>CARTER</u>			
16. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-36-3574B</u>		17. INFORMANT <u>Rev. O. B. Langrall, 416 Chapel Gate Lane</u>	
18. <u>15-3.01</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>CA of ascending transverse colon c</u> <u>due to, or as a consequence of:</u> <u>metastasis to Liver.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) <u>—</u>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Multiple sclerosis</u>					
19A. DATE OF OPERATION <u>6/16/70</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA of the transverse colon</u>	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> 19 <u>70</u> to <u>6/27</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6/26</u> 19 <u>—</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Mayuree Khongcharoensuk M.D.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/27/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>MAYUREE KHONGCHAROENSUK M.D.</u>		23D. ADDRESS <u>Bon Secours Hosp. Baltimore Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>6/30/70</u>	24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave., 21228</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

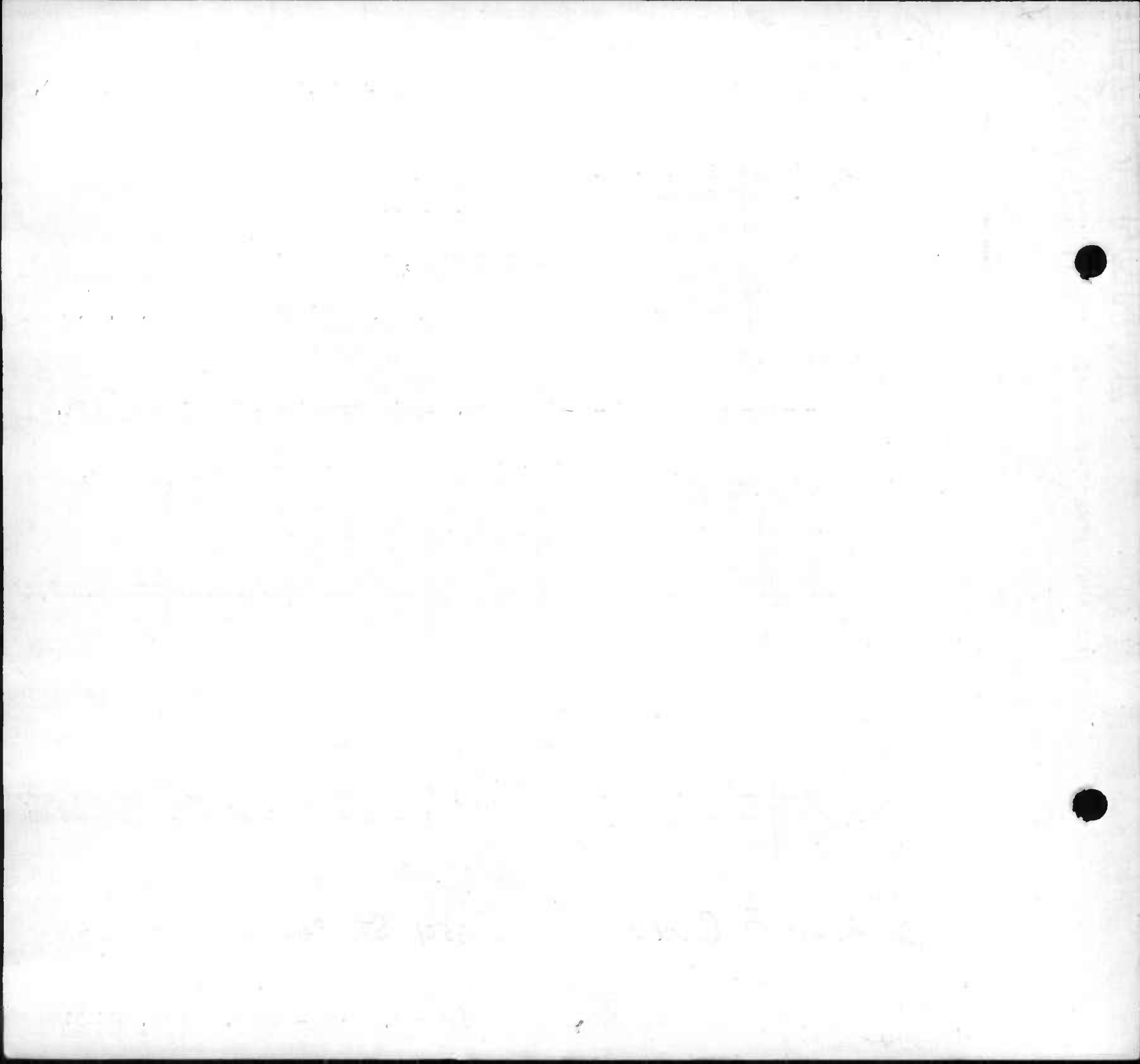
BALTIMORE CITY HEALTH DEPARTMENT				70 6539		REG. NO. 70 6539	
BIRTH NO. 1-240		70 6539		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Edward Vogel				2. DATE AND HOUR OF DEATH 6/26/70 4:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY 2864 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4502 Old Frederick Road			
5. SEX male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/04	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel			14. MOTHER'S MAIDEN NAME Etta				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown			16. SOCIAL SECURITY NO. 220-03-2027		17. INFORMANT Mrs. Isabel Vogel, 4502 Old Frederick Road		
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Caecoma Left lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary fibrosis + Emphysema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH many years							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/26 9/18 19 66 to 6/26 19 70 , that (I) (we) last saw the deceased alive on 6/26 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. My associates							
23A. SIGNATURE Edward W. Johnson M.D.				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) Dr. E.W. Johnson Md.				23D. ADDRESS 3432 Frederick Ave. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70		24C. NAME OF CEMETERY or CREMATORY Godd Shepherd Cemetery		24D. LOCATION (City, town, or county) (State) Rogers Ave., Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke Funeral Home		25D. ADDRESS 4101 Edmondson Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6540	
K-625 70 6540		CERTIFICATE OF DEATH		70 6540	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Buczkowska Martha Karczmarek		2. DATE AND HOUR OF DEATH June 26, 1970 8:40 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines, Belvedere 2525 W. Belvedere Avenue		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1724 Aliceanna Street			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 26, 1915	9. AGE (In years last birthday) 54	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME John Buczkowski		14. MOTHER'S MAIDEN NAME Mary Piluk		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-0823		17. INFORMANT ADDRESS Mrs. Sophia Chrusniak - 1724 Aliceanna St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 124X I Widespread metastatic CA		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Breast (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 1 yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/18 19 70 to 6/26/ 19 70, that (I) (we) last saw the deceased alive on 6/24 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alan B. Cohen				23B. DATE SIGNED 6/29/70	
23C. PHYSICIAN'S NAME (Type) DR. ALAN B. COHEN				23D. ADDRESS 3501 ST. PAUL ST. - APT. #243	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/70		24C. NAME OF CEMETERY or CREMATORY Dedman Hill Cemetery	
24D. LOCATION (City, town, or county) Brooklyn, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUN 29 1970			
24F. NAME OF REGISTRAR John E. Taylor		24G. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. #21231			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 6541	
<div style="display: flex; justify-content: space-between;"> X-631 70 6541 </div>				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) FRANK J. KRATFEL				2. DATE AND HOUR OF DEATH 6/27/70 2:40 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2609			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 713 Fagley Street #21224			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1909		9. AGE (in years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Corp.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Stephen Kratfel				14. MOTHER'S MAIDEN NAME Anna Tancibok			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-7421		17. INFORMANT ADDRESS Anna C. Kratfel - 713 Fagley St. #21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Generalized carcinomatosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Ca of lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH wks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 6/8 19 70 to 6/27 19 70 that (we) last saw the deceased alive on 6/27 19 70 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (view) the body after death.							
23A. SIGNATURE Barbedo, M.D.				23B. DATE SIGNED 6/27		23C. PHYSICIAN'S NAME (Type) BARBEDO, M.D.	
23D. ADDRESS MERCY HOSP.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/70		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR George A. Weber		ADDRESS 705 S. Ann St. #21231	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 6542 CERTIFICATE OF DEATH					Registered No. 70 6542				
1. NAME OF DECEASED (Type or Print) <u>Ruby E Foxwell</u>					2. DATE AND HOUR OF DEATH <u>6/22/70</u> <u>3:00p</u> M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hosp.</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2755</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>2211 N. Rogers Ave.</u> D. STREET ADDRESS (If rural, give location) <u>B276</u>				
5. SEX <u>F</u>		6. RACE <u>N W</u>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>12/1/1893</u>		9. AGE (In years last birthday) <u>76</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Winfield Murphy</u>					14. MOTHER'S MAIDEN NAME <u>Gellie Jo Murphy</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>212-12-2039</u>		17. INFORMANT <u>The Wesley Home</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Stroke</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>MI.</u> <u>urinary tract infection</u>					CAUSE OF DEATH <u>Stroke</u> <u>MI.</u> <u>urinary tract infection</u>				
19. DATE OF OPERATION <u>0</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>sepsis</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <u>6/11</u> <u>1970</u> <u>to</u> <u>6/22</u> <u>1970</u> , that (I) (we) lost saw the deceased alive on <u>6/22</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Michael G. G.</u> M.D.					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>6/22/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael G. G.</u>					23D. ADDRESS M.D. <u>Byrnes Funeral Home Baltimore</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>25 June 70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dorchester Memorial Park</u>			24D. LOCATION (City, town, or county) (State) <u>Cambridge Md</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey</u>			25C. FUNERAL DIRECTOR <u>Byrnes Funeral Home Baltimore</u>				

1884
The 1st of May
to the 31st of May

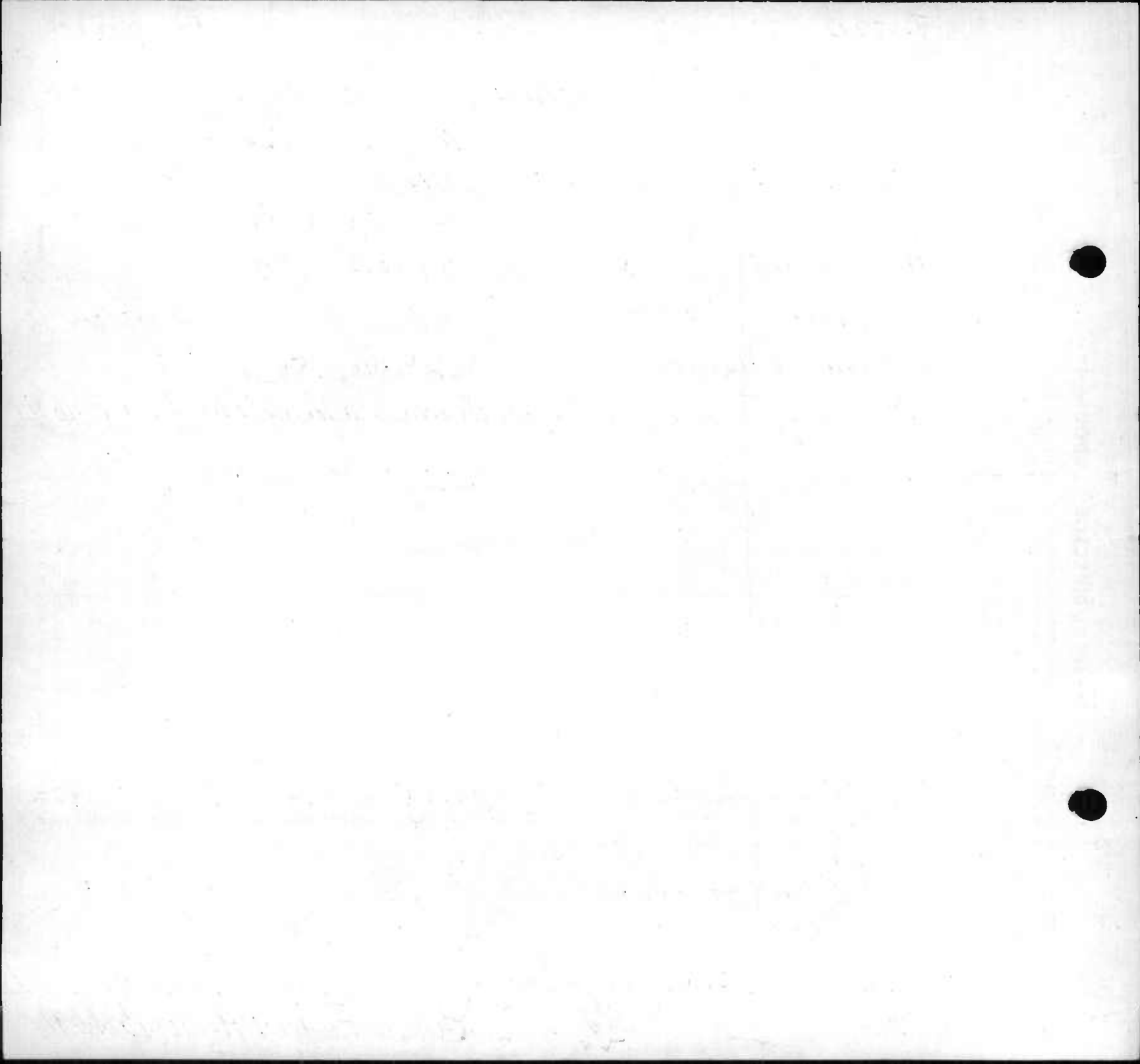
Received of Mr. J. H. [unclear]
the sum of \$100.00

For the year ending 31st Dec 1884
J. H. [unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

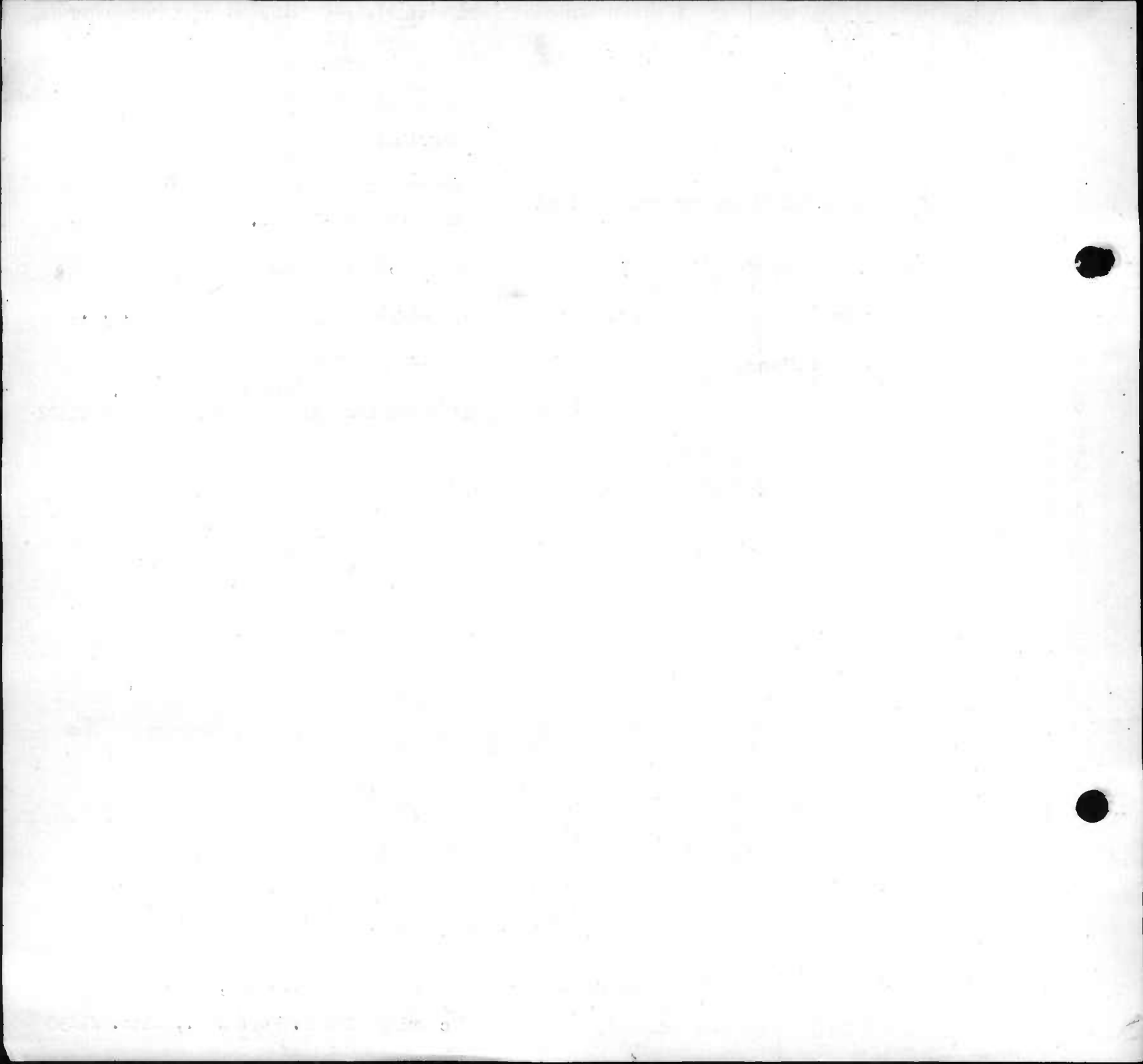
Baltimore City Health Department				REG. NO. 70 6543	
7-520 70 6543				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Joseph B Thomas		June 22 1970 5:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
90 House in the Pines Belvedere				Md	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
3923 Falls Rd					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
Male	White		7/6/1915	94	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Engineer			Steel		Md
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Nelson Thomas			Caroline Stolp		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No			213 09 1597		Deanie Underkoffler 3908 Falls Rd
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				3 days	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				Congestive heart failure	
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/27 1954 to 6/22 1970, that (I) (we) last saw the deceased alive on 5/5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Reuben Hoffman, M.D.				6-25-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
REUBEN HOFFMAN				8466 W. 36 St	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		June 26 1970		St Abrahams Cem	
				Beckleysville Bldg Co Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 29 1970		John B. ...		By ...	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

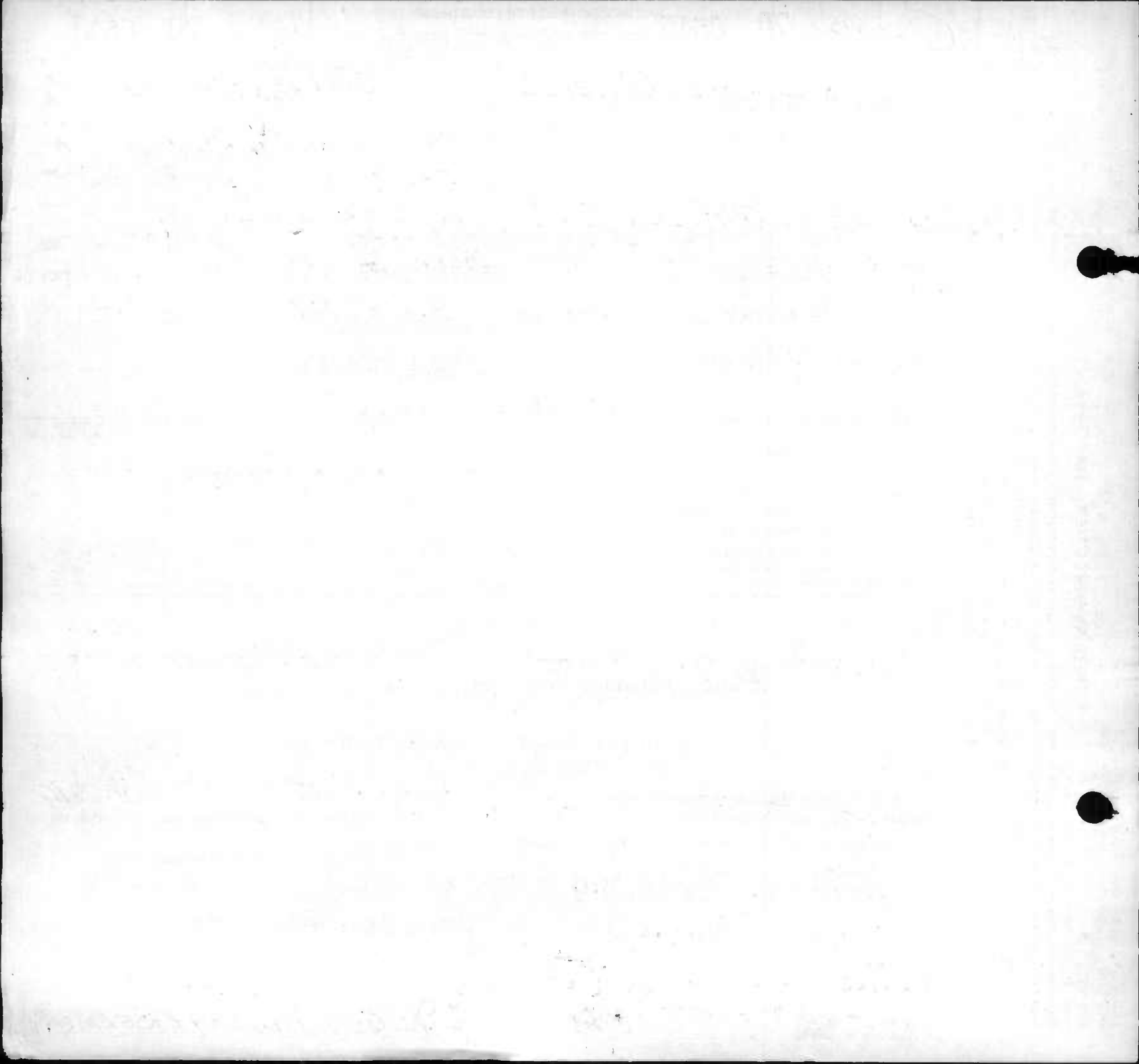
B-520 70 6544				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6544	
1. NAME OF DECEASED (Type or Print) Joseph S. Bianco				2. DATE AND HOUR OF DEATH June 25, 1970 11:45 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2302 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 26 East Wheeling St.			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1907		9. AGE (In years last birthday) 63		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10B. KIND OF BUSINESS OR INDUSTRY Furniture		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salvadore Bianco				14. MOTHER'S MAIDEN NAME Marion Purazza			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218 10 5916		17. INFORMANT ADDRESS Elizabeth Lessner Pasadena, Maryland 21122			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 203X + E931.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic heart disease.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Serum hepatitis (B) Multiple myeloma (C) _____			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from June 16 19 70 to June 25 19 70 , that (1) (we) last saw the deceased alive on June 25 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Cecilia V. Tomas MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED June 25, 1970	
23C. PHYSICIAN'S NAME (Type) DEGREE				23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (State) Brooklyn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Fort Ave., Balto. 21230	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6545	
0-540 70 6545					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM E. O'NEILL		2. DATE AND HOUR OF DEATH JUNE 23, 1970 10:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2749			
FULL NAME OF HOSPITAL OR INSTITUTION 001603 HEATHFIELD ROAD		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1603 HEATHFIELD RD.		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY BAKERY		8. DATE OF BIRTH 1901 DECEMBER 68	
13. FATHER'S NAME JAMES O'NEILL		14. MOTHER'S MAIDEN NAME MARY FRAZER		9. AGE (In years last birthday) 68	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-3739A		17. INFORMANT FAMILY	
18. 150X I		CAUSE OF DEATH		ADDRESS SAME	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Adenocarcinoma Esophagus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASHD		10 yr.	
19A. DATE OF OPERATION 02/13/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma Esophagus		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 27 1965 to JUNE 23 1970 , that (I) (we) last saw the deceased alive on JUNE 19 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stephen Toms, MD		23B. DATE SIGNED 6/24/70		23C. PHYSICIAN'S NAME (Type) Stephen Toms, MD	
23D. ADDRESS 1712 Winford Rd		23E. FUNERAL DIRECTOR J. Walter Conklin		23F. ADDRESS 5444 BELAIR RD	
24A. BURIAL OR CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-27-70		24C. NAME OF CEMETERY NEW CATHEDRAL	
24D. LOCATION (City, town, or county) (State) BALTO., MD		24E. DATE REC'D BY HEALTH DEPT. JUN 25 1970		24F. NAME OF REGISTRAR Charles E. [unclear]	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PAUL JAMES JANISKI		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year June 25, 1970		Hour 9:35 A. M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital		3. DATE PRONOUNCED DEAD Month Day Year June 25, 1970		Hour 9:35 A. M.
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5300		
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Towson Baltimore 21204
9. DATE OF BIRTH 9-30-30-		10. AGE (In years last birthday) 39	E. STREET AND NUMBER 1066 Marleigh Circle	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James S. Janiski
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman		14B. KIND OF BUSINESS OR INDUSTRY #####		15. MOTHER'S MAIDEN NAME Stella A. Staszak
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korea		17. SOCIAL SECURITY NO. 213-30-0450		18. INFORMANT John S. Janiski, 9001 Weatherlane Garth, Baltimore, Md.
19. E-8231.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Massive pulmonary thromboemboli DUE TO, OR AS A CONSEQUENCE OF: (B) Fractures of left lower leg DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Pier		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Newkirk Street Pier-Cottman Company
22D. TIME OF INJURY (APPROX.) 5-12-70 1:30 P. m.		22E. INJURY OCCURRED: WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject pinned under truck while trying to make escape after truck toppled over
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		M.D. Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 25, 1970
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-1970		24C. NAME of CEMETERY or CREMATORY Sacred Heart Of Mary
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 28 1970		
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Wm. Cook-Brooks		
ADDRESS Towson, Md. 21204		ADDRESS 1050 York Road		

ACADEMY EXTEND

1
S-352

70 6547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6547

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles R. Stengel

(RUSSEL C. STENDEL)

2. DATE OF DEATH
Known ☐ Month Day Year Hour
Estimated ☐ 6 22 70 9:35 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED

00 4147 Marx Avenue 9-2-70

3. DATE PRONOUNCED DEAD
Month Day Year Hour
6 22 70 9:35 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md. B. COUNTY 2741

6. SEX

male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

19 APR 1914

10. AGE (in years last birthday)

56

11. Under 1 Yr. 12 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

4147 Marx Avenue

11. BIRTHPLACE (State or foreign country)

PA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

FRED STENDEL

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BARTENDER

14B. KIND OF BUSINESS OR INDUSTRY

TAVERN

15. MOTHER'S MAIDEN NAME

BEKHA GRILL

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

186-10-3165

18. INFORMANT

ADDRESS

NETTIE COLLINS, 4147 MARX AVE. 21206

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Acute bronchopneumonia

PERDINEXZ

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) Chronic emphysema of lungs

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Arteriosclerotic cardiovascular disease

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

6-22-70

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL/REMOVAL

24B. DATE

26 JUN 70

24C. NAME OF CEMETERY or CREMATORY

Mt. Pleasant SACRAMENT

24D. LOCATION

BOYERSOWN, PA.

25A. DATE REC'D BY HEALTH DEPT.

JUN 29 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

WALTER H. HONER, M.D.

ADDRESS

W.D. OTT F.H. BOYERSOWN, PA.

Letter from M.E.'s office
Letter from M.E.'s office

7-2-70 M.H.
9-2-70 M.H.

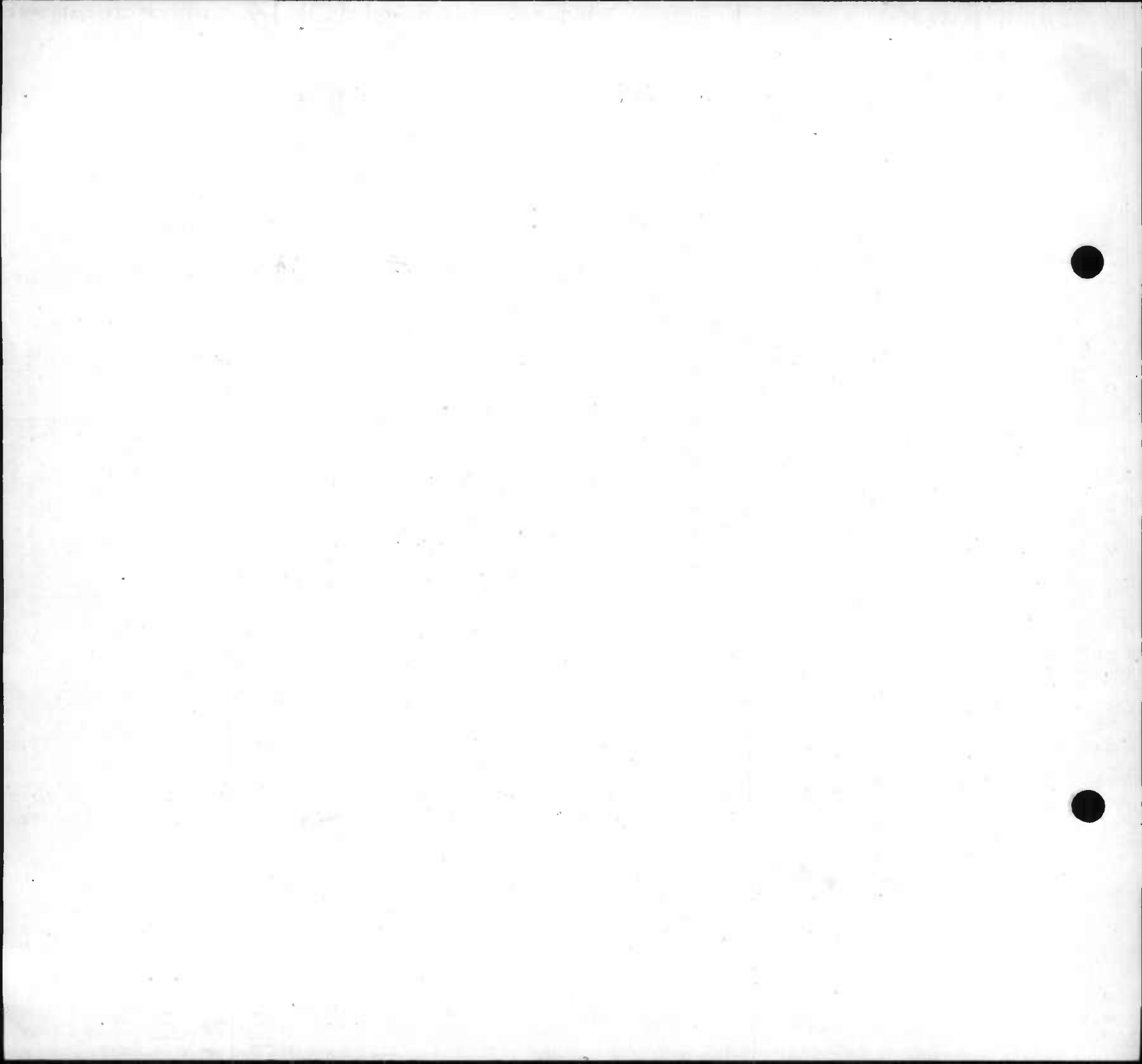
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6548	
Y-320 70 6548				CERTIFICATE OF DEATH	
BIRTH NO. Y-320 70 6548			1. NAME OF DECEASED (Type or Print) YATES, Jane (Jannie)		
2. DATE AND HOUR OF DEATH June 28, 1970 1:15 A.M.			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing & Convalescent Ctr. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1604			5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
6. STREET AND NUMBER 807 North Monroe 21217			7. AGE (In years lost birthday) 74		
8. DATE OF BIRTH 9-15-95			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown Charles Dawson			14. MOTHER'S MAIDEN NAME Unknown Pattie Booker		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 138-30-4711		
17. INFORMANT Wm. Dawson			ADDRESS same		
18. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Septic DUE TO, OR AS A CONSEQUENCE OF: (B) Diabetic Ulcers with Gangrene DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD with Acute Compensated Respiratory Failure Collapse of Veins and Central Stems Arteries		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Months Years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from October 9 1969 to June 28 1970 , that (I) (we) last saw the deceased alive on June 28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter H. Rheinstein, MD				23B. DATE SIGNED June 28, 1970	
23C. PHYSICIAN'S NAME (Type) PETER H. RHEINSTEIN, MD				23D. ADDRESS 1111 Park Avenue, Baltimore, Md 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-70		24C. NAME of CEMETERY or CREMATORY Odd Fellows Cemetery	
24D. LOCATION (City, town, or county) Burlington, N.J.		24E. STATE (State) N.J.			
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Bailey, R.R.		25C. FUNERAL DIRECTOR V. Bailey	
25D. ADDRESS Nelson F.H. 1348 Calhoun St.					



C-200

70

6549

BALTIMORE CITY HEALTH DEPARTMENT

70

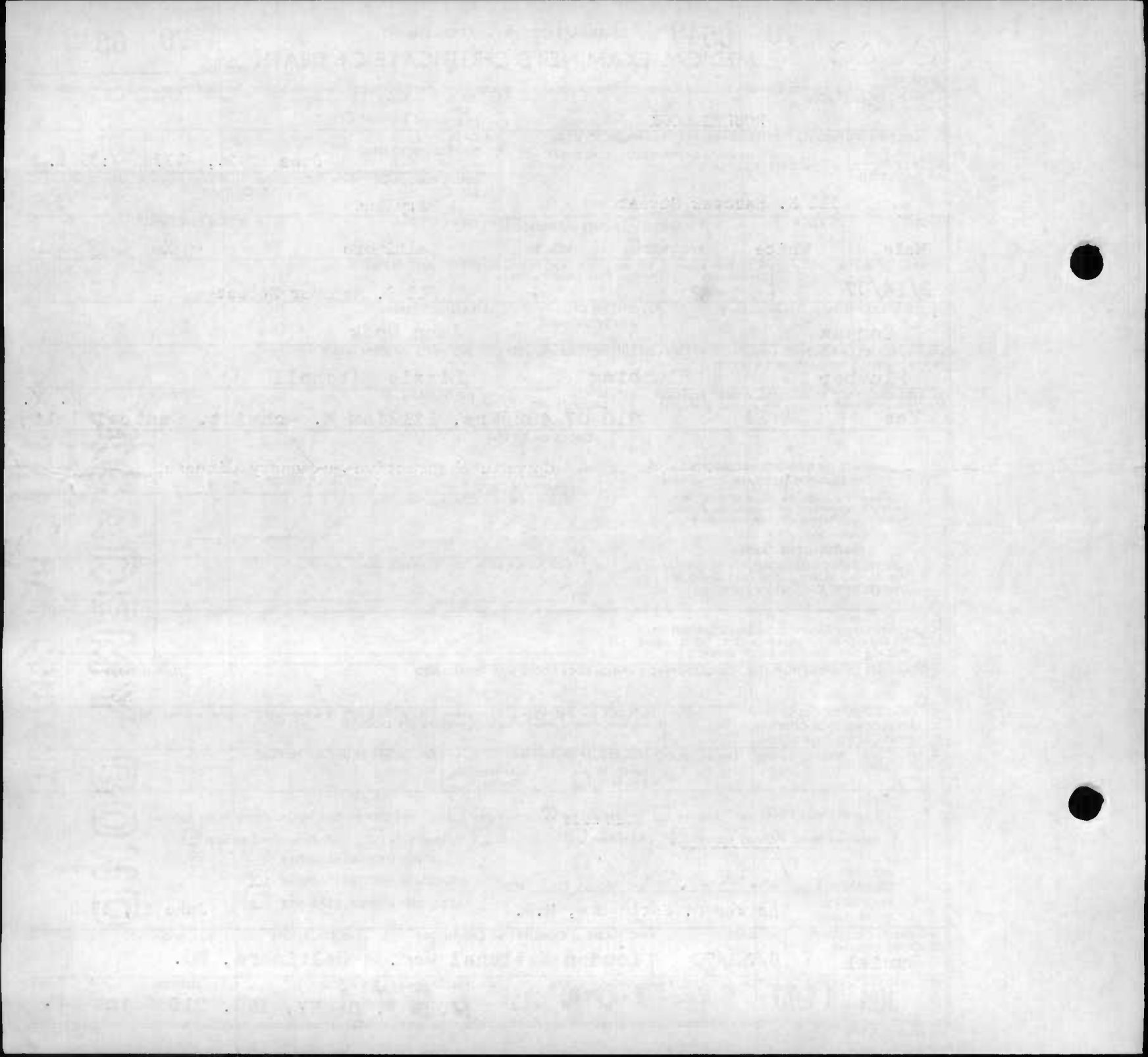
6549

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT COOK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 511 S. Hanover Street		3. DATE PRONOUNCED DEAD Month Day Year Hour June 24, 1970 7:55 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9/14/07		10. AGE (In years lost birthday) 62	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Cook		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2201	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		14B. KIND OF BUSINESS OR INDUSTRY Plumbing	
15. MOTHER'S MAIDEN NAME Lizzie Mitchell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II	
17. SOCIAL SECURITY NO. 218 07 4825		18. INFORMANT Mrs. Lillian M. Schmidt. Central Islip	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Chronic obstructive pulmonary disease (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 6/30/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 25, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/70	
24C. NAME of CEMETERY or CREMATORY Loudon National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT JUN 29 1970		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR JOHN P. DENNY, INC.		ADDRESS 715 Light St.	



BIRTH NO.		6550		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 6550	
1. NAME OF DECEASED (Type or Print)				MICHAEL JEROME MORRIS		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				3. DATE PRONOUNCED DEAD		Month Day Year Hour		6 27 1970 12:05 A.M.	
FULL NAME OF HOSPITAL OR INSTITUTION				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE Md. B. COUNTY 1506	
Sinai Hospital (DOA)						C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
6. SEX Male				7. RACE Negro		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH				10. AGE (in years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
10-13-50				19		Baltimore, Maryland		U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14b. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
NAVY						NAOMI KELLAM			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
Yes Active				213-52-1456		Mr. James Wm. Morris		Same	
19. CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		GunsHOT wound of neck	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)		yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		1512	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
6-26-70 11:40 P.M.				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Shot during altercation.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type)				Isidore Mihalakis, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		6-27-70	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial				7-1-70		Baltimore National		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 28 1970				MORTON & DYETT F. H.		1701 Laurens Street			

22C

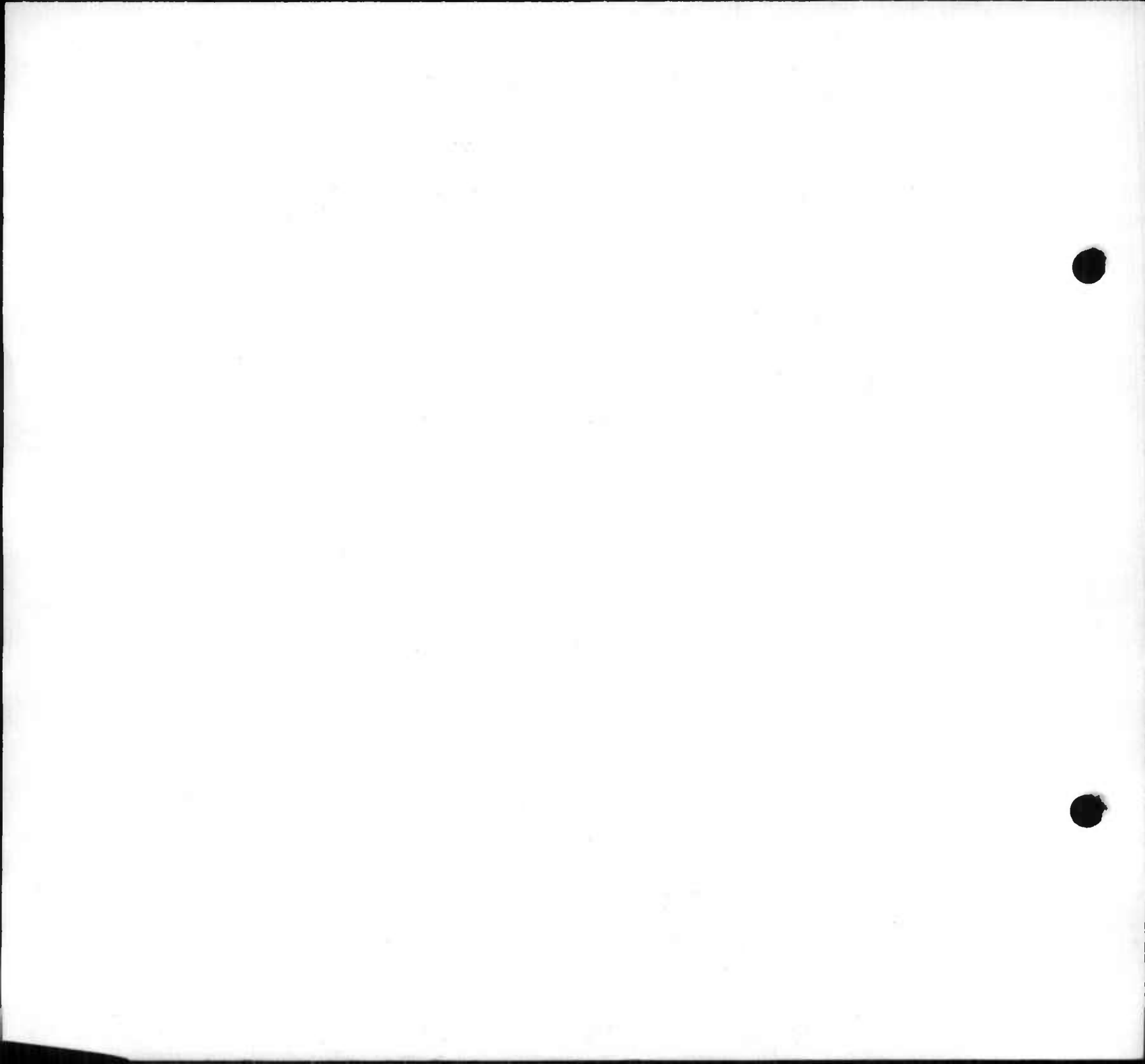
3551 Park Heights

ME Office

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

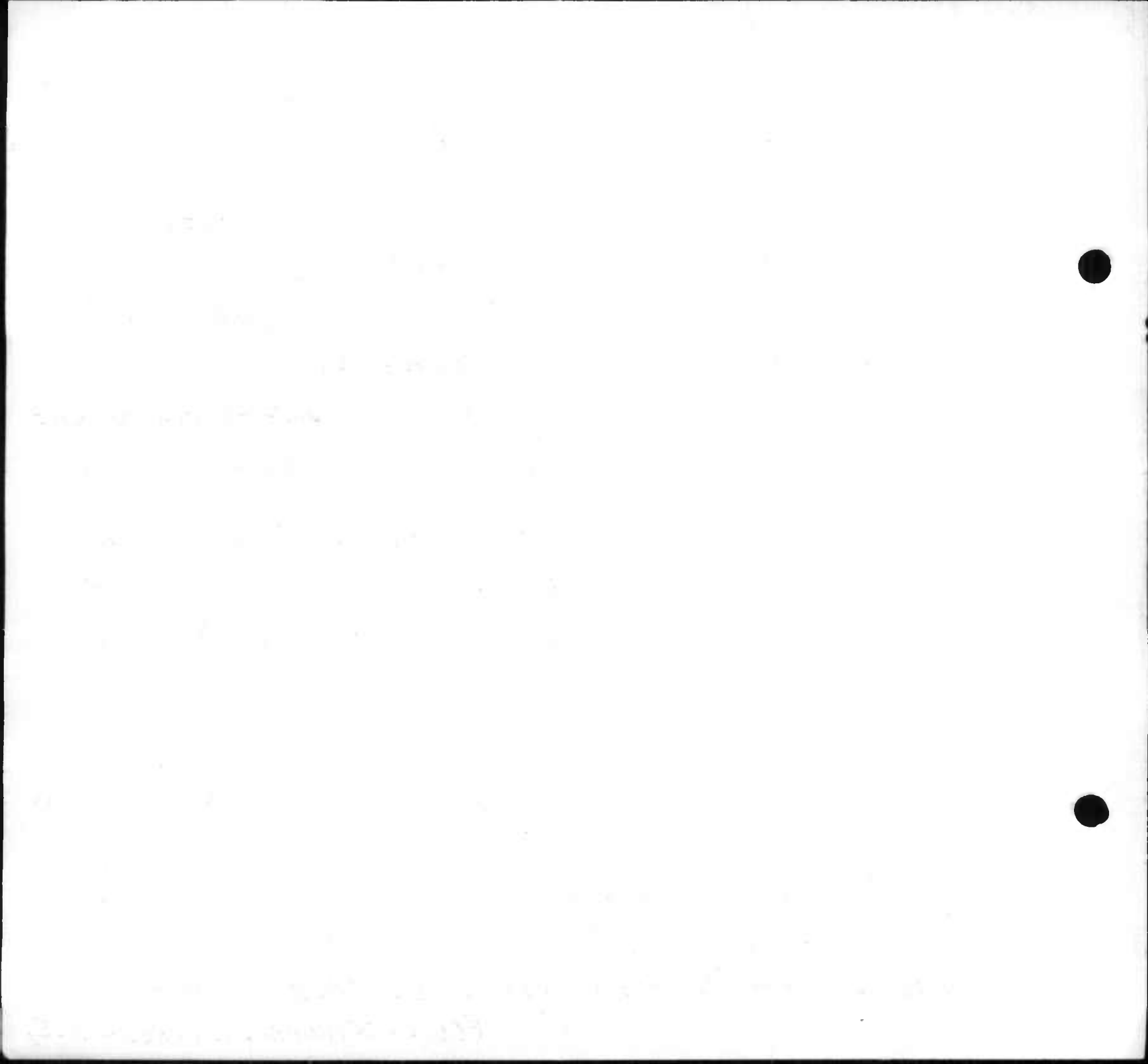
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6551</u>	
BIRTH NO. <u>70 6551</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Louis M. McDermott</u>			2. DATE AND HOUR OF DEATH <u>23 June 70 1 30 P M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>401</u>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>06-12-07</u> 9. AGE (In years last birthday) <u>63</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGEMENT</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>HOTEL MANAGER</u>		
11. BIRTHPLACE (State or foreign country) <u>Penn</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Henry McDermott</u>			14. MOTHER'S MAIDEN NAME <u>Mary Resrdon</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>173-09268</u>		
17. INFORMANT <u>Hospital Chart</u>			ADDRESS		
18. <u>412.21</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>CUA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASCVD & hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u> <u>cirrhosis, esophageal varices</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>06-16-70</u> 19 <u>70</u> to <u>06-23</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>06-23</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. Cepeda M.D.</u>			23B. DATE SIGNED <u>23 June 70</u>		
23C. PHYSICIAN'S NAME (Type) <u>M. Cepeda M.D.</u>			23D. ADDRESS <u>Union Memorial Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-26-70</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>WM. J. TICKNER & SONS</u>	
				ADDRESS <u>Penn</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

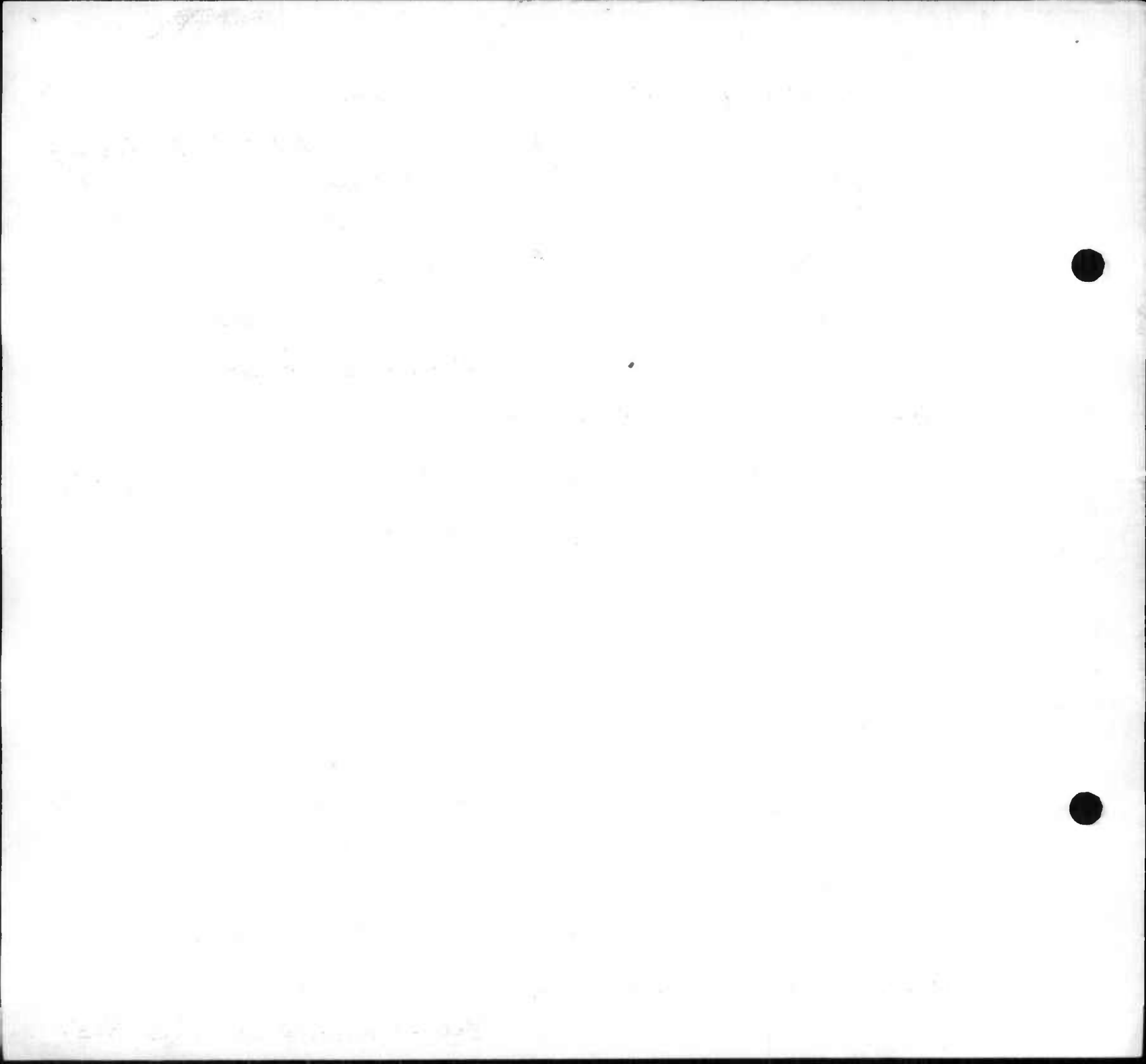
70 6552		BALTIMORE CITY HEALTH DEPARTMENT		70 6552	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) MARTIN, EARLE		2. DATE AND HOUR OF DEATH 6/27/70 4:10 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. CITY			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI Hospital		C. CITY OR TOWN CITY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTO MD		E. STREET AND NUMBER 1716 WILKINS AVE.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/05	9. AGE (In years last birthday) 65	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME GRACE L.		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT CHART WIFE - ETHEL JEANETTE	
18. 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF: CHRONIC LUNG DISEASE ASCOD		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours Years Years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II (Reason for Hospitalization) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). BENIGN Prostatic Hypertrophy		Years	
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/23 19 70 to 6/27 19 70 that (I) (we) last saw the deceased alive on 6/27/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Earle H. Cherry, M.D.		23B. DATE SIGNED 6/27/70		23C. PHYSICIAN'S NAME (Type) Earle H. Cherry M.D.	
23D. ADDRESS SINAI Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 6-30-70		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER BALTO.		24D. LOCATION (City, town, or county) (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR GEO. L. SCHWAB	
				ADDRESS 2101 FREDK AVE.	



FUNERAL DIRECTOR: IMPORTANT

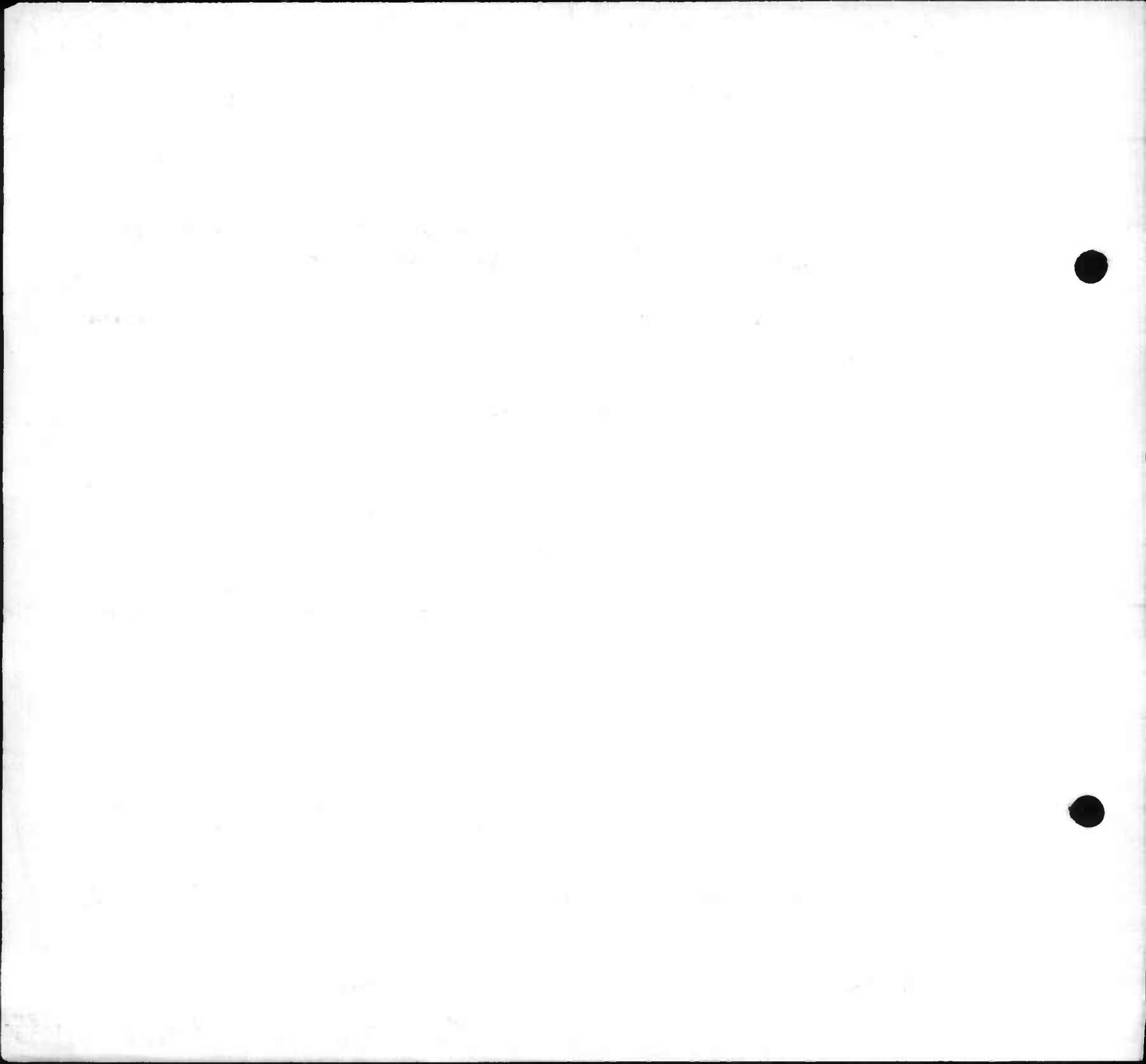
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-5001		70 6553		BALTIMORE CITY HEALTH DEPARTMENT		X		70 6553	
CERTIFICATE OF DEATH				REG. NO.					
1. NAME OF DECEASED (Type or Print) <u>Catherine Sutton Cain</u>				2. DATE AND HOUR OF DEATH <u>6-26-70</u> <u>2:00 p.m.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>ANNE ARUNDEL</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>425 SINAI HOSPITAL of Balt.</u>				C. CITY OR TOWN <u>PASADENA</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <u>CYRIL AV. Box 454 05200</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-21-22</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>MILORED FONA</u>				ADDRESS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>140165232</u>		17. INFORMANT <u>PATIENT'S Hosp. record.</u>			
18. <u>174X I</u> CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>TERMINAL CARCINOMA</u>				<u>17 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>CARCINOMA of Left Breast</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>12 mo.</u>	
(C) _____									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>0</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>6-9-70</u> to <u>6-26-70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6-26-70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>G. Mamaril, Jr.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6-26-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>ANSELMO G. MAMARIL, JR.</u>				23D. ADDRESS <u>SINAI HOSPITAL of BALTIMORE</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6-29-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>WESTERN</u>		24D. LOCATION <u>BALD. MD.</u>		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u>				25B. NAME OF REGISTRAR <u>James E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>GEO. L. SCHWAB</u>			
						ADDRESS <u>2101 FRED. AVE.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

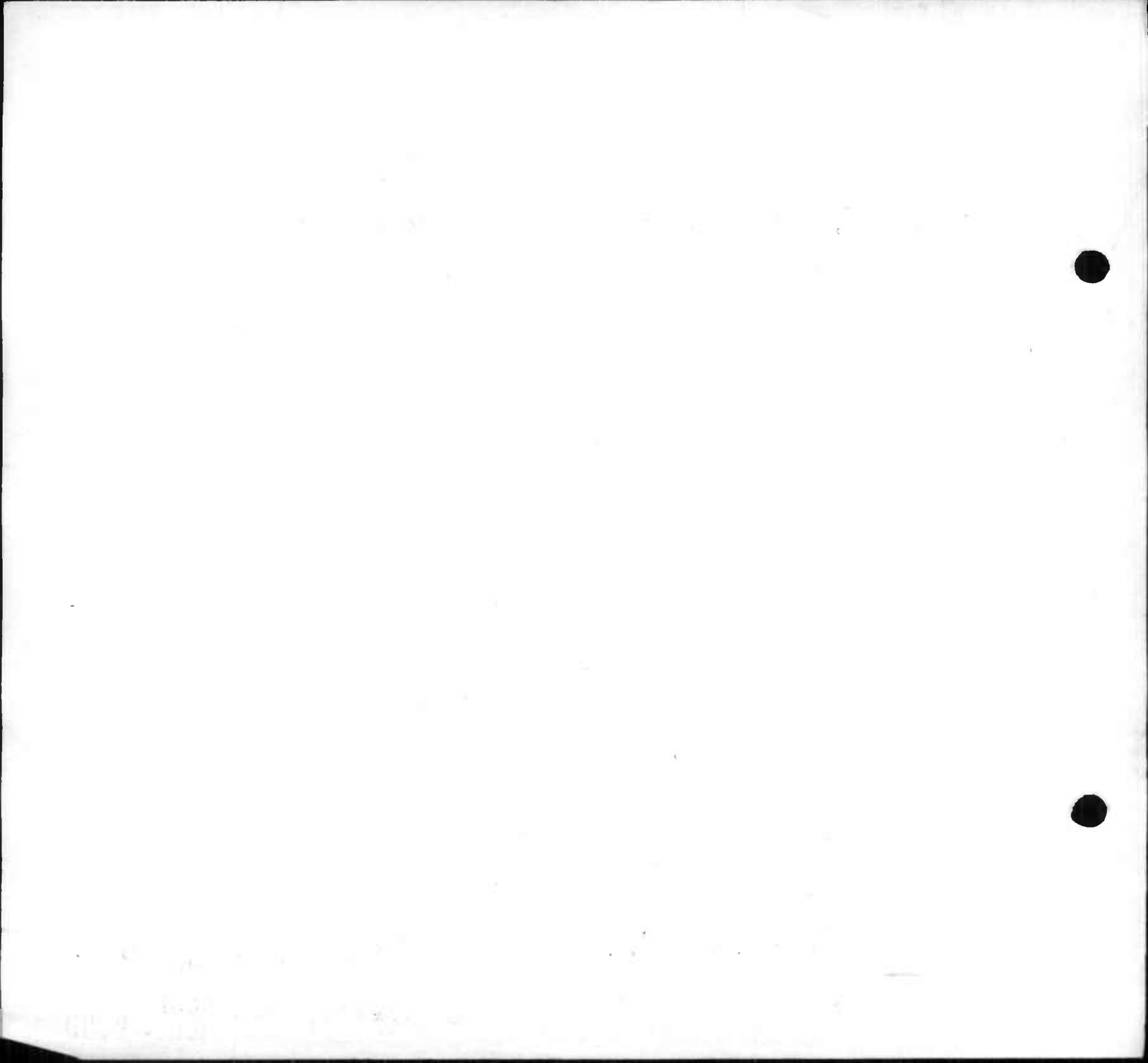
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
P-200 70 6554				70 6554	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Frank Picha</u>			2. DATE AND HOUR OF DEATH <u>6/26/70 8:00 AM 6:00 A M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Edgewood Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Balto</u> B. COUNTY <u>2745</u>		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3203 Northern Parkway</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/7/1901</u>		9. AGE (in years lost birthday) <u>68</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist Mgr.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-5241</u>	17. INFORMANT <u>Marie M. Picha-3203 Northern Pkwy.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary embolus?</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>36 hr</u>
			(B) <u>Left heart failure</u>		<u>1 mo</u>
			(C) <u>Coronary atherosclerosis</u>		<u>3+ yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 22 1970</u> to <u>June 26 1970</u> that (I) (we) last saw the deceased alive on <u>June 24 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frederick J. Vollmer MD</u>			23B. DATE SIGNED <u>6-26-70</u>		23C. PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>6/29/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>
24D. LOCATION <u>Baltimore</u>			24E. LOCATION (City, town, or county) (State) <u>Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Robert C. Altenburg Funeral Home, Inc.</u>	
				ADDRESS <u>6009 Harford Rd. - Balto., Md. 21214</u>	



BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILHELM PIETERS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 6-24-70 Hour 11:00A M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospitals		3. DATE PRONOUNCED DEAD Month Day Year JUNE 24 1970 Hour 11:00A M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 202	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH April 26-1916		10. AGE (In years lost birthday) 54	11. BIRTHPLACE (State or foreign country) Holland		12. CITIZEN OF WHAT COUNTRY U.S.A.
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Unk	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 108-18-7196		18. INFORMANT Wife ADDRESS Same	
19. E9651 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of trunk DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Gough and Ann Streets 202	
22D. TIME OF INJURY (APPROX.) 6-24-70 10:35 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 25, 1970 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/27/70		24C. NAME OF CEMETERY or CREMATORY Lake View	
24D. LOCATION (City, town, or county) (State) Balto Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970			
25B. NAME OF REGISTRAR Robert A. Taylor		25C. FUNERAL DIRECTOR J. S. Connelly, Inc. - Essex Md.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) MAY CROSS		2. DATE AND HOUR OF DEATH 7/5/70 18:30 A			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 302			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOUSE IN THE PINES BELVEDERE BELVEDERE AVENUE BALTIMORE, MARYLAND 21204		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 107 Albemarle Street					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/92	9. AGE (in years last birthday) 78	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 1538 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pelvic metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Carcinoma of Colon. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 1 yr.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/17 19 70 to 7/5 19 70 that (I) was lost saw the deceased alive on 6/24 19 70 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death.					
23A. SIGNATURE Alan B. Cohen M.D.		23B. DATE SIGNED 7/7/70		23C. PHYSICIAN'S NAME (Type) Alan B. Cohen M.D.	
23D. ADDRESS 6821 Reisterstown Road Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) 7-9-70		24B. DATE 7-9-70			
24C. NAME OF CEMETERY JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD		24D. NAME OF REGISTRAR Robert E. Farley M.D.			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Farley M.D.			

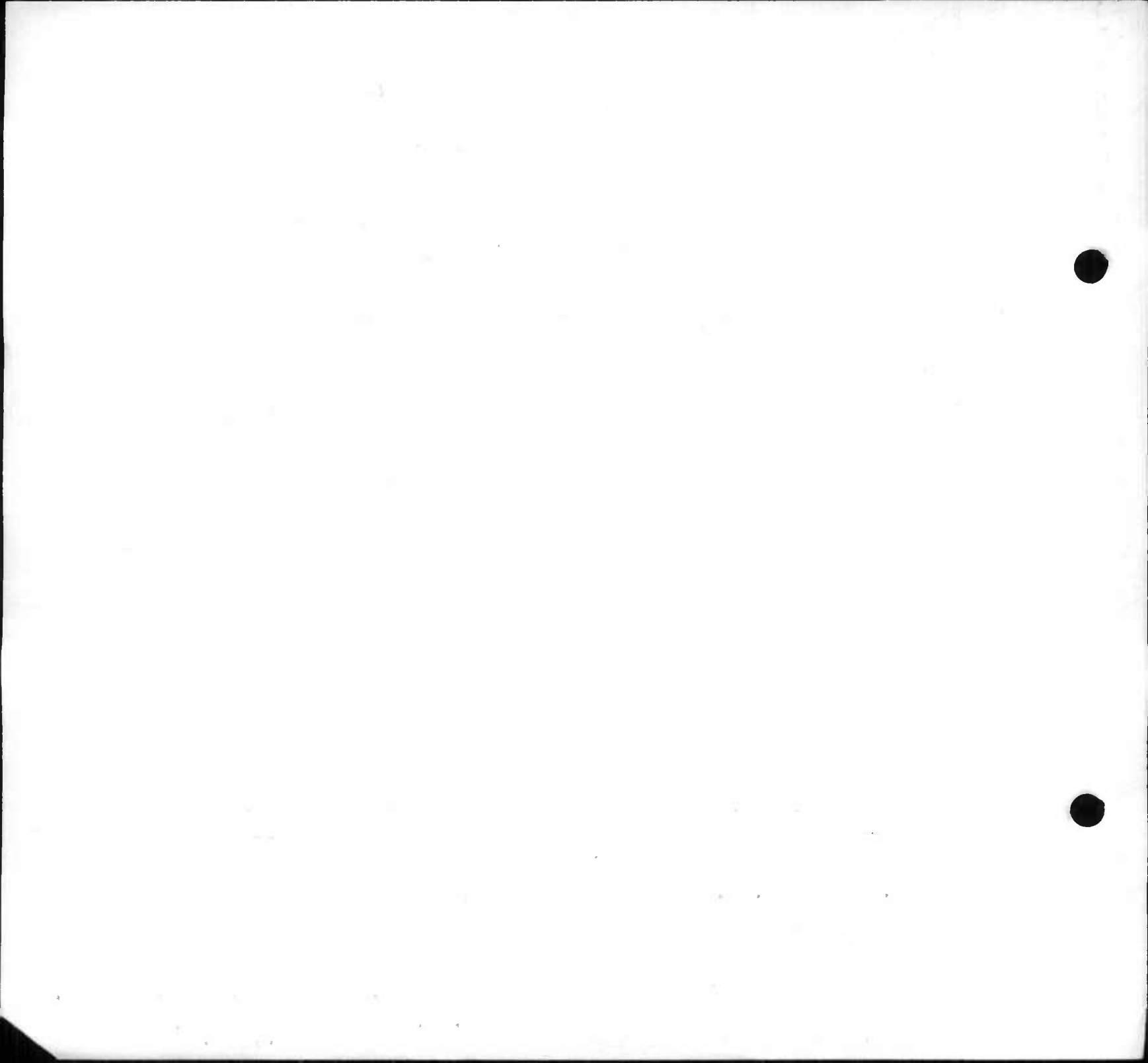


Released by medical examiner's office.

FUNERAL DIRECTOR: IMPORTANT

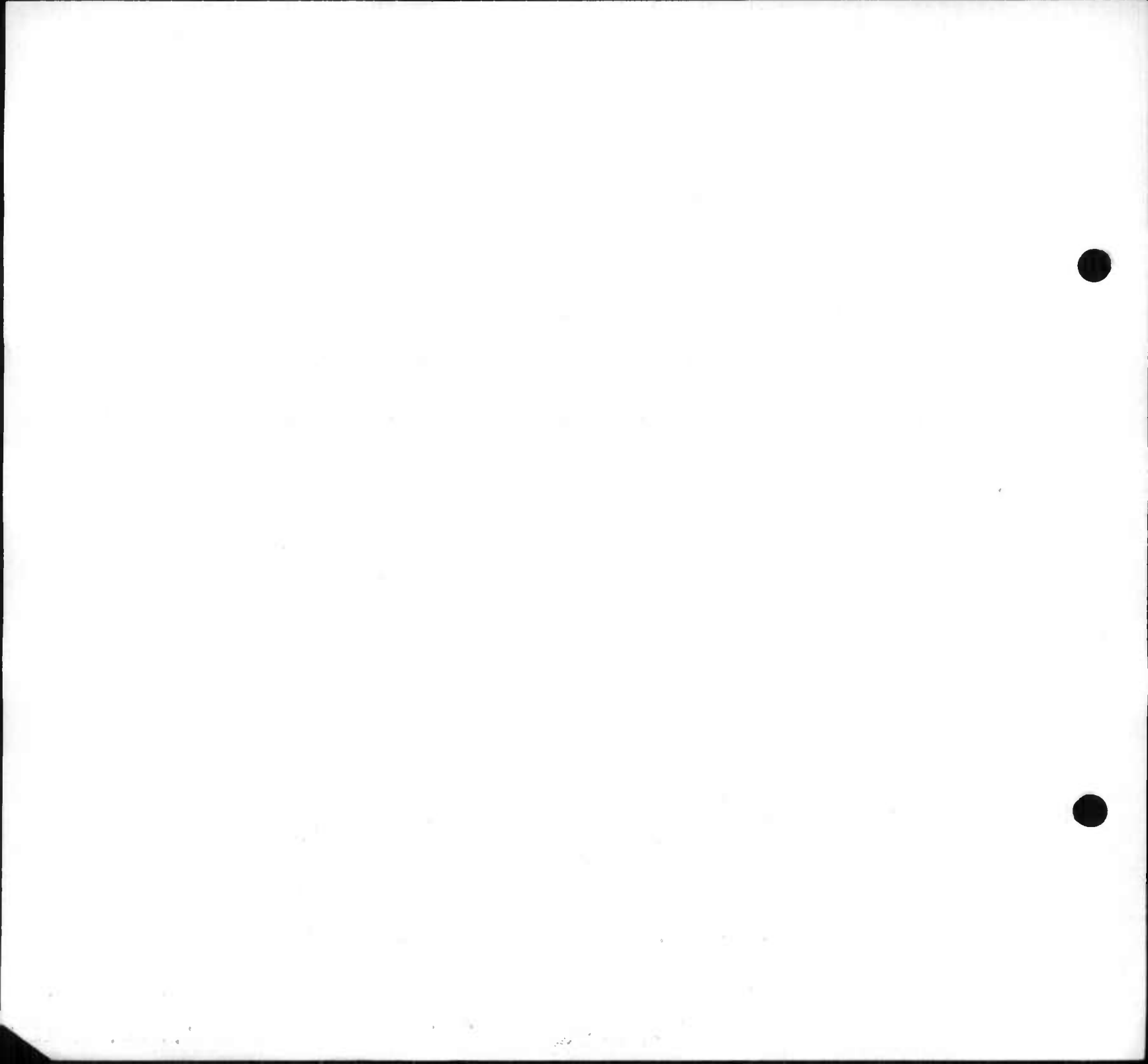
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120 70 6557		BALTIMORE CITY HEALTH DEPARTMENT		70 6557	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		Davis John		2. DATE AND HOUR OF DEATH 6-23-70 16 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md		B. COUNTY 1201	
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 105 Wendover Rd.			
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-28-02	9. AGE (in years last birthday) 67	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BROKER - STOCK		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mass.	
13. FATHER'S NAME ARTHUR E. DAVIS		14. MOTHER'S MAIDEN NAME MARY CHENEY		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. CATHERINE L. DAVIS (SAME)	
18. 4-4-191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ruptured Aortic Aneurysm 2 hours (B) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: years (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Liver cirrhosis					
19A. DATE OF OPERATION 2-23-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured aortic Aneurysm		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-23-70 to 6-23-70 that (I) (we) last saw the deceased alive on 2-23-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Albert C. W. Montague		23B. DATE SIGNED 6/23/70		23C. PHYSICIAN'S NAME (Type) Albert C. W. Montague	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 6/26/70		24C. NAME of CEMETERY or CREMATORY Lorraine Park Mausoleum, Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR B. W. Jenkins & Sons Co., 4905 York Rd., Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

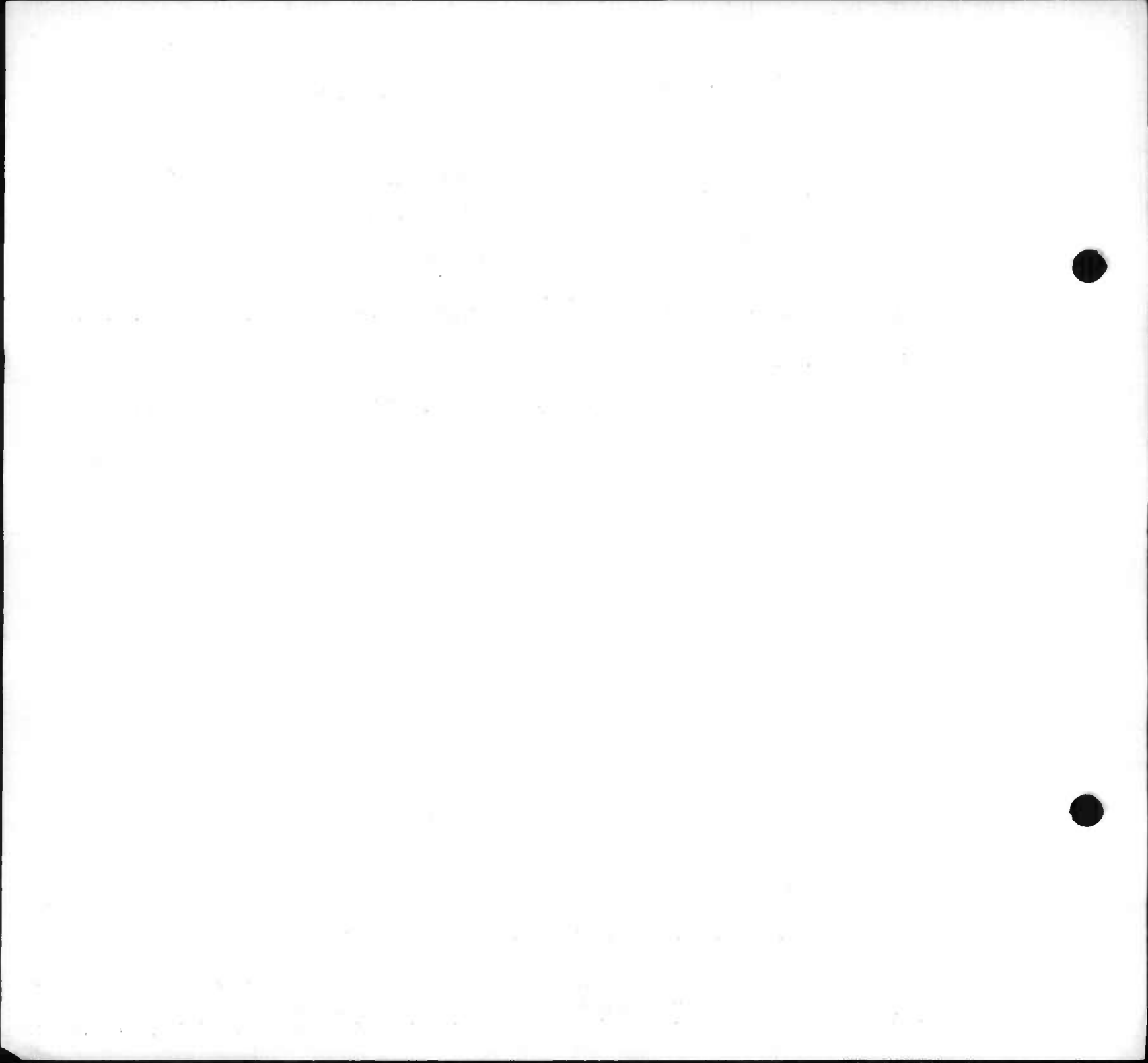
BALTIMORE CITY HEALTH DEPARTMENT				70 6558		REG. NO. 70 6558	
BIRTH NO. M-635				70 6558		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CATHERINE M. MARTIN				2. DATE AND HOUR OF DEATH 6/25/70 945 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 903 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3654 OLD YORK ROAD			
5. SEX WF	6. RACE FW	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/85	9. AGE (In years last birthday) 84	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM L. DAVIES				14. MOTHER'S MAIDEN NAME NANCY BLAKE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-6942		17. INFORMANT ADDRESS MRS. CATHERINE GILL 3654 OLD YORK RD. BALTIMORE MD 21218			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE <u>Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/16 19 70 to 9/25 19 70 that (I) (we) last saw the deceased alive on 9/25 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Anne L. Leddy				23B. DATE SIGNED 6/25/70		23C. PHYSICIAN'S NAME (Type) Dr. Anne L. Leddy	
23D. ADDRESS Union Memorial Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70		24C. NAME OF CEMETERY or CREMATORY Woodlawn		24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd. Balto., Md. 21211	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

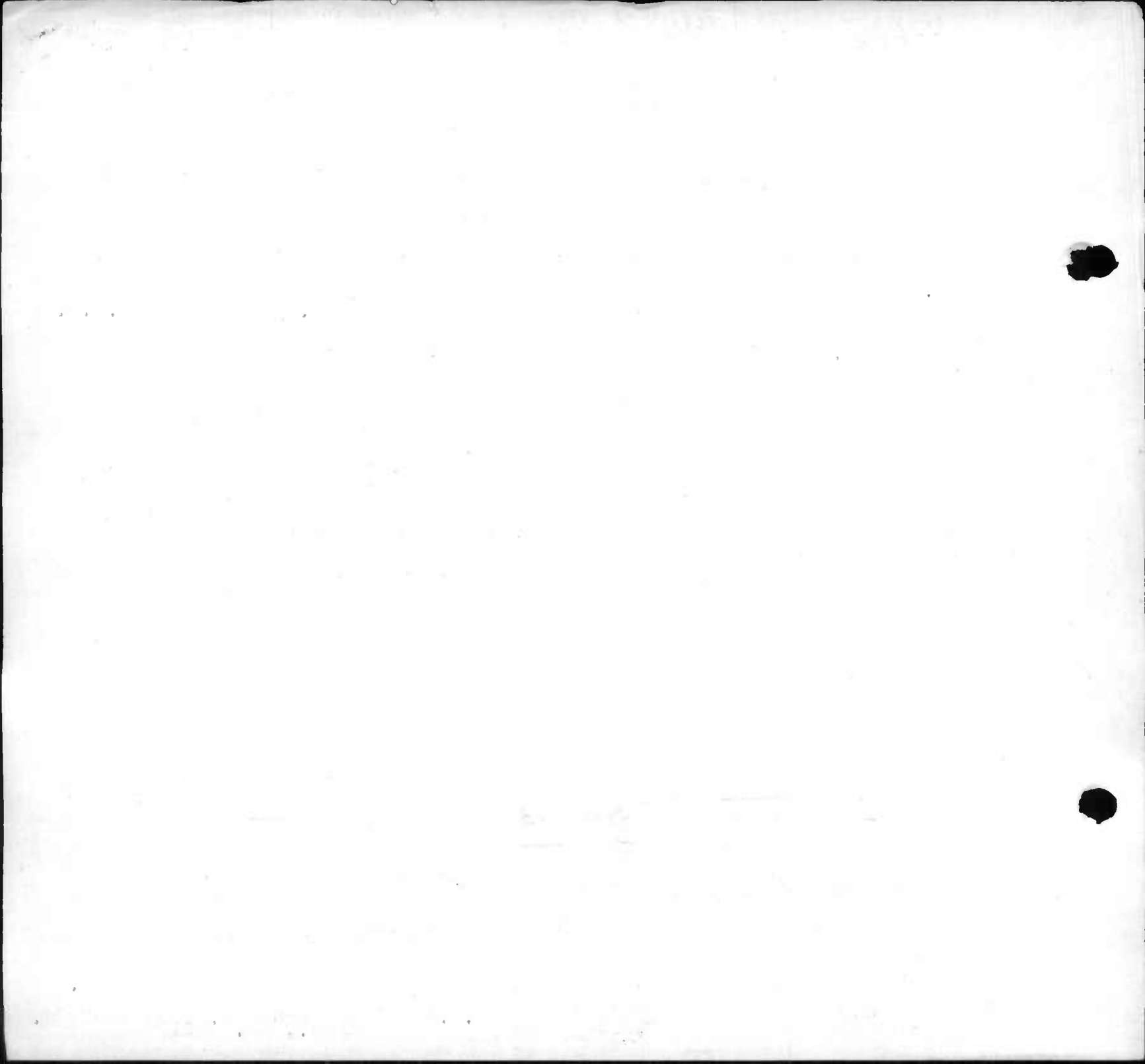
N-400		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6559	
BIRTH NO. 70 6559		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Roy C. Neely		2. DATE AND HOUR OF DEATH June 24, 1970 11:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3711 Rexmere Road		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE Maryland B. COUNTY 903 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3711 Rexmere Road			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-2-1892	9. AGE (in years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired President		10B. KIND OF BUSINESS OR INDUSTRY Rubber Co. Schenuit Tire &		11. BIRTHPLACE (State or foreign country) Clarion County, Penn.	
13. FATHER'S NAME Henry G. Neely		14. MOTHER'S MAIDEN NAME Cora Wise			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-8101		17. INFORMANT Mrs. Lillian Neely ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.41-183X Arteriosclerotic Cardiovascular Disease DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Ca of Prostate		74yrs.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1976 to June 1970 that (I) (we) last saw the deceased alive on June 24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Com. H. Kammer, Jr.		23B. DATE SIGNED 26 June 70		23C. PHYSICIAN'S NAME (Type) Dr. Wm. H. Kammer, Jr.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-70		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) Baltimore County,		24E. (State) Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

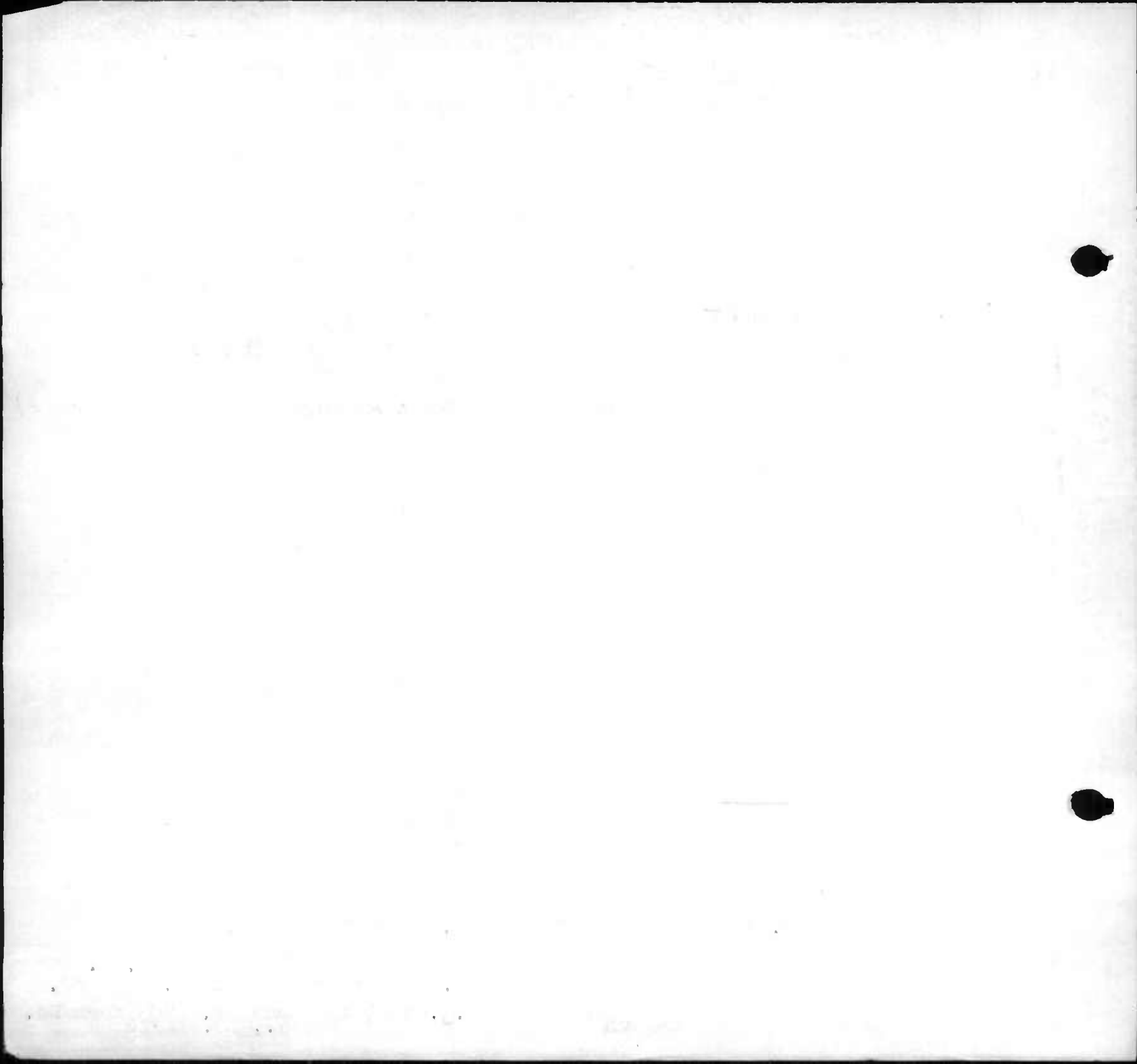
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6560	
BIRTH NO. H-616 70 6560		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MRS. Edna Duvall HARPER		2. DATE AND HOUR OF DEATH JUNE 23, 1970 10:31 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 314 Southway		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1201 C. CITY OR TOWN Baltimore 21218 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 314 Southway			
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1887	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Louis M. Duvall			14. MOTHER'S MAIDEN NAME Laura Kauffman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-4058D		17. INFORMANT Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE UREMIA DUE TO, OR AS A CONSEQUENCE OF: (B) URETERAL OBSTRUCTION, bilateral DUE TO, OR AS A CONSEQUENCE OF: (C) CARCINOMA of UTERUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 5 months 7 years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 011-4-63		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA of uterus		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1962 19 JUNE 23 19 70, that (I) (we) last saw the deceased alive on JUNE 23 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel P. Asper M.D.				23B. DATE SIGNED 6/23/70	
23C. PHYSICIAN'S NAME (Type) SAMUEL P. ASPER M.D.				23D. ADDRESS Johns Hopkins Hospital, Baltimore Md. 21205	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/26/70		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970			
25B. NAME OF REGISTRAR Robert E. Jenkins, R.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-242		70 6561		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 6561	
BIRTH NO.				CERTIFICATE OF DEATH			
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)			
				GUS G. MESOLOGITES			
2. DATE AND HOUR OF DEATH				6-26-70 4:15 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
MARYLAND GENERAL HOSPITAL				MARYLAND			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				BALTIMORE			
D. STREET ADDRESS (If rural, give location)				1720 Lakeside Ave 21218			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days	If Under 24 Hrs. Hours: Min.	
M	W	M	12-31-87	82			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
RETIRED MERCHANT					GREECE		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE MESOLOGITES				ELIZABETH MILLIOS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		218 32 1810		MRS. NIKI MESOLOGITES (SAME)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ACUTE MYOCARDIAL INFARCTION							
ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-20 1970 to 6-26 1970, that (I) (we) last saw the deceased alive on 6-26 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Gregorio Marfori						6-26-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Gregorio Marfori				Md. General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Entombment		6/29/70		Greek Orthodox Cem.		Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUN 29 1970		Robert E. Barber		H. W. Jenkins & Sons Co.		4905 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

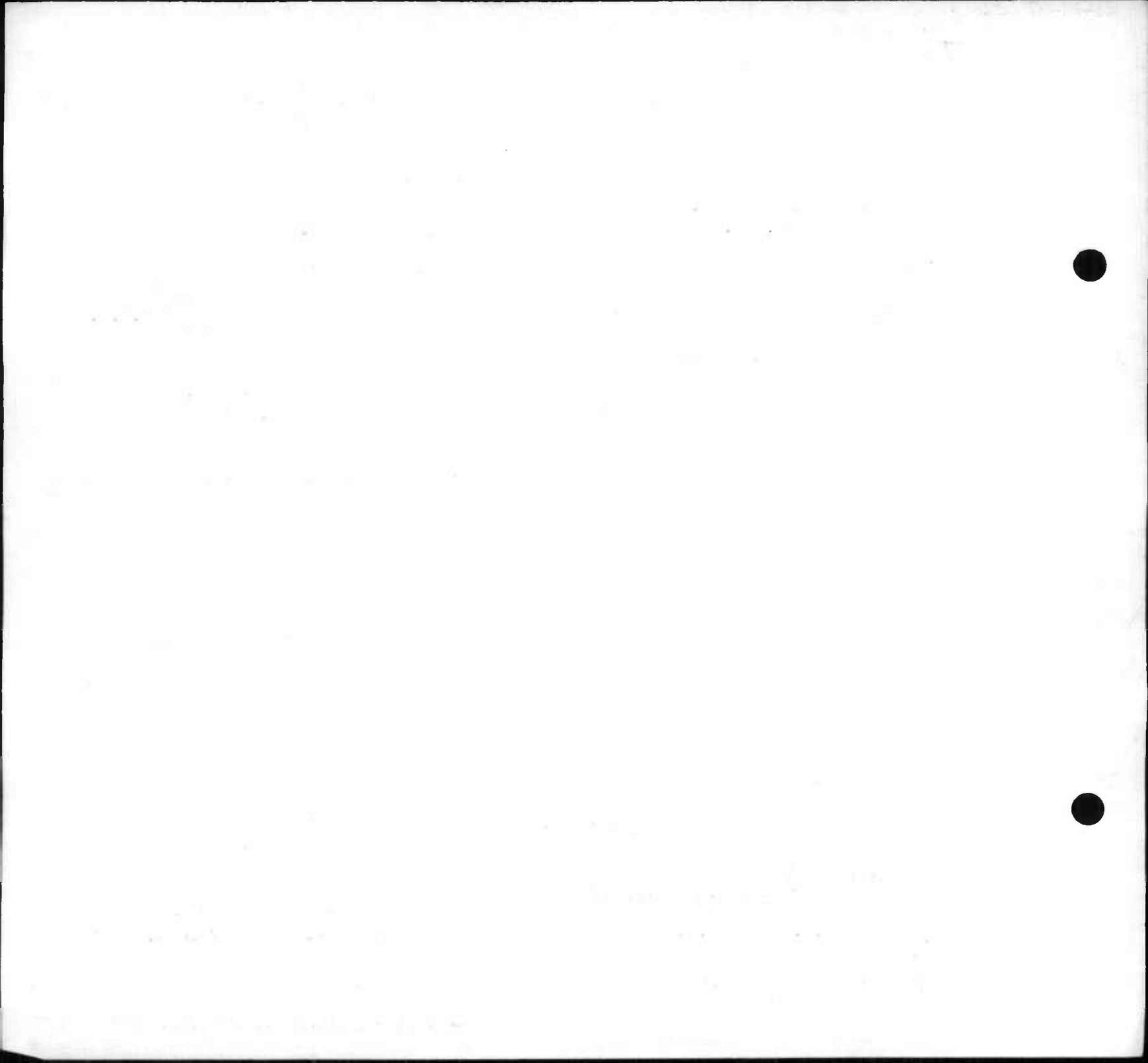
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 6562	
BIRTH NO. 70 6562		1. NAME OF DECEASED (Type or Print) KATHARINE W. BOLTON		2. DATE AND HOUR OF DEATH 6/26/70 9 37 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital 44				A. STATE MD. B. COUNTY Baltimore 5600			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER RFD 4 Sykesville			
5. SEX F	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 23 1920	9. AGE (In years last birthday) 50	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME NELSON W. WARRICK				14. MOTHER'S MAIDEN NAME LORETTA HANCOCK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-50-6080		17. INFORMANT GOUGH W.T. BOLTON		ADDRESS SAME	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatic Failure			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/22 to 6/26 19 70 and that (I) (we) last saw the deceased alive on 6/26 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. V. RIBEIRO MD				23B. DATE SIGNED 6-26-70			
23C. PHYSICIAN'S NAME (Type) H. V. RIBEIRO MD				23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 6-29-70		24C. NAME OF CEMETERY or CREMATORY GREENMOUNT		24D. LOCATION (City, town, or county) (State) BALTIMORE MD	
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR H.W. JENKINS & SONS CO. BALTO., MD.		ADDRESS	

RFD 4
Sykesville, Md is
Address

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.		70 6563	
K-620 70 6563				CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ALICE M. TURSCH</u>		2. DATE AND HOUR OF DEATH <u>6/27/70</u> <u>1:00 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md 21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
				C. CITY OR TOWN <u>MIDDLE RIVER</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>1339 Willow Rd. 21222 005</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1916</u>	9. AGE (In years last birthday) <u>54</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSPECTOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CROSSE & BLACKWELL CO</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter BAVERN SCHUB.</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>017-09-4359</u>		17. INFORMANT <u>4940 Eastern Ave. ADDRESS</u> <u>Baltimore, Md 21224</u>			
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHRONIC PULMONARY DISEASE</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/22/70</u> 19 to <u>6/27/70</u> 19 that (I) (we) last saw the deceased alive on <u>6/27/70</u> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J.R. Wands M.D.</u>				23B. DATE SIGNED <u>6-27-70</u>			
23C. PHYSICIAN'S NAME (Type) <u>J.R. Wands M.D.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>JUNE 30 1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CAK LAWN CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>EASTERN AVE BLVD BALTO MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 29 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>THE DIPPEL BROS INC</u>		ADDRESS <u>1800 E LOMBARD ST</u>	



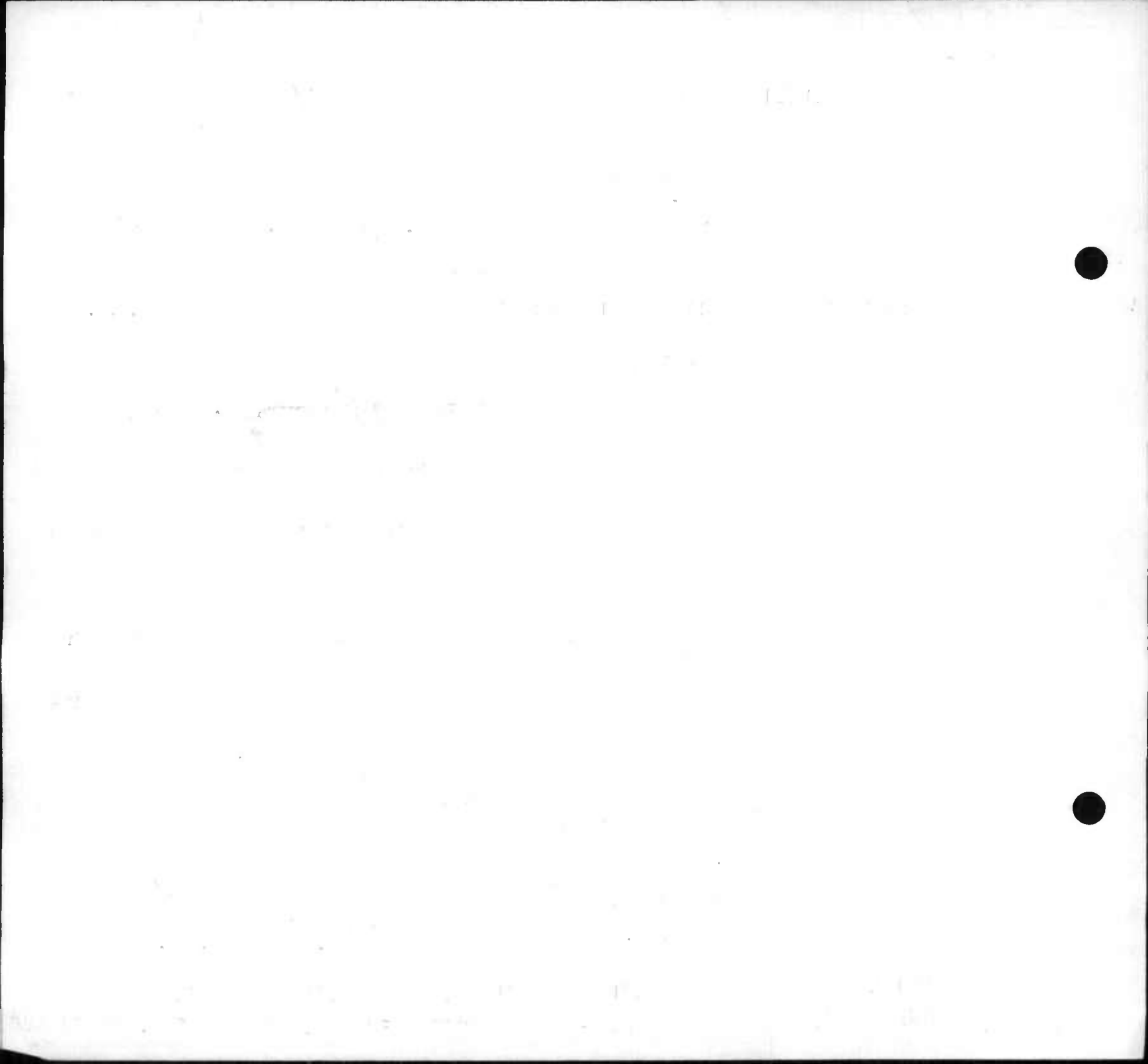
CERTIFICATE OF DEATH

REG. NO. 70 6564

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 6564		2. DATE AND HOUR OF DEATH 6/25/70 1:00 PM M.	
1. NAME OF DECEASED (Type or Print) LILLIAN ODESSA HOWARD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1547	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY CARVER HIGH SCHOOL Maryland	
13. FATHER'S NAME Alexander Tyler		14. MOTHER'S MAIDEN NAME Vonzella EVANS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-20-0784	
17. INFORMANT FREDERICK A. HOWARD		ADDRESS 2814 LONGWOOD ST	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bacterial Pneumonia and sepsis 1 week (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Lymphoblastic leukemia 4 months (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Fungus cavity in the lung 1 month OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 4, 1970 to June 25, 1970 that (I) (we) last saw the deceased alive on June 25, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Marc Colmer M.D.		23B. DATE SIGNED 6/25/70	
23C. PHYSICIAN'S NAME (Type) Marc Colmer M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/29/70	
24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL CEM.		24D. LOCATION (City, town, or county) BALTIMORE MARYLAND	
25A. DATE RECD BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS NOTTER FUNERAL HOME 3035 W. NORTH AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

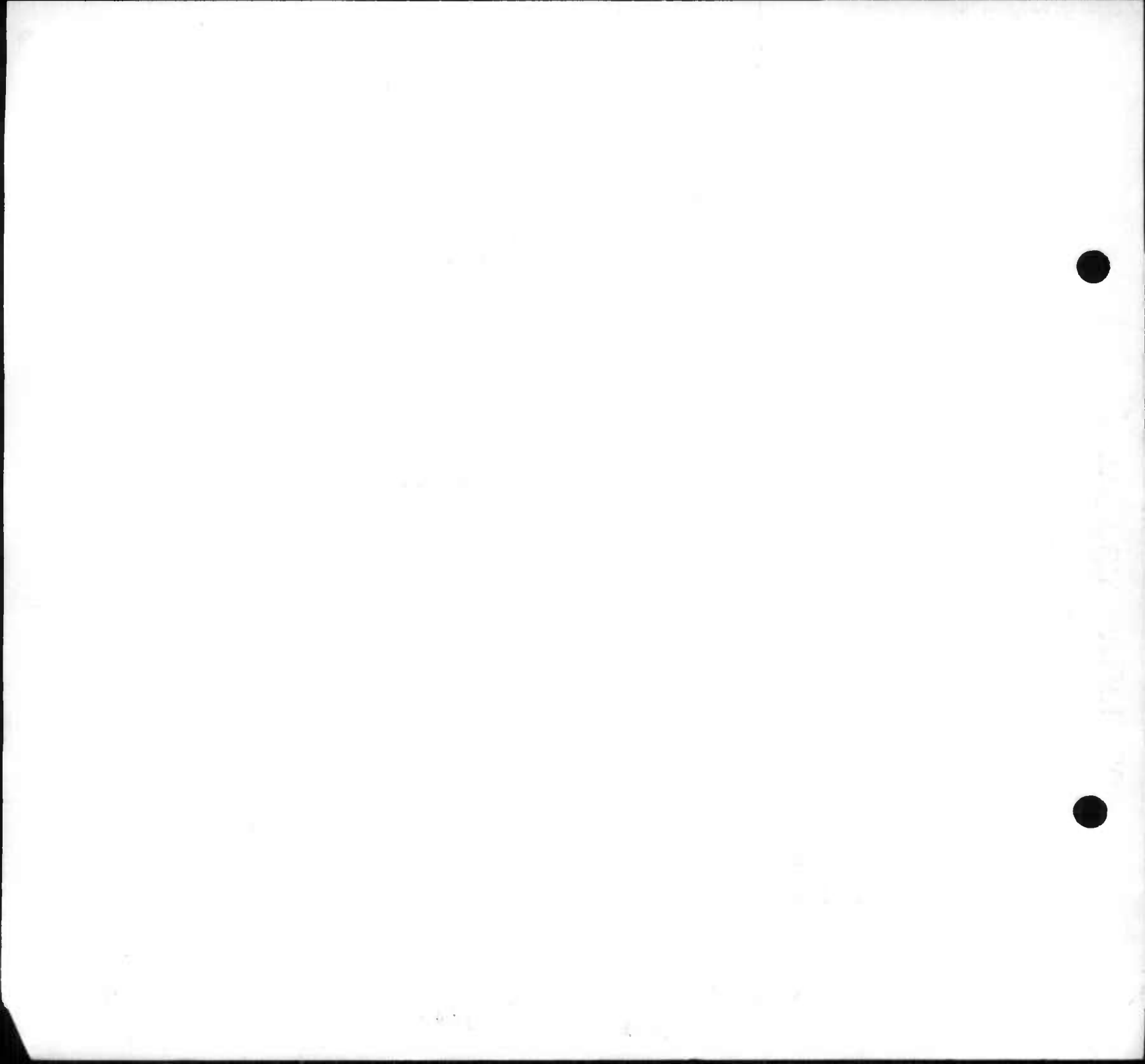
<p>P-453 70 6565</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 70 6565</p>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MRS. VIOLA PLANTER		2. DATE AND HOUR OF DEATH 6/26/70 4:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1401		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hosp. 2025 West Fayette Street Baltimore, Md.		E. STREET AND NUMBER 301 McMechen Street			
5. SEX Female	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/18/96	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY PRIVATE FAMILY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Richard Harris		14. MOTHER'S MAIDEN NAME GRACE POLLOCK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-32-0526		17. INFORMANT LILLIE GRIFFIN 2116 W. BALTIMORE ST.	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Metastatic CA of the Lung		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>6/5</u> 19 <u>70</u> to <u>6/26</u> 19 <u>70</u> that (I) (<u>we</u>) last saw the deceased alive on <u>6/26</u> 19 <u>70</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (<u>did not</u>) view the body after death.					
23A. SIGNATURE Mayuree Khongcharoensuk, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/26/70	
23C. PHYSICIAN'S NAME (Type) MAYUREE KHONGCHAROENSUK, M.D.		23D. ADDRESS Bon Secours Hosp. Baltimore Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6/26/70		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM. BALTIMORE MARYLAND	
24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. JUN 29 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

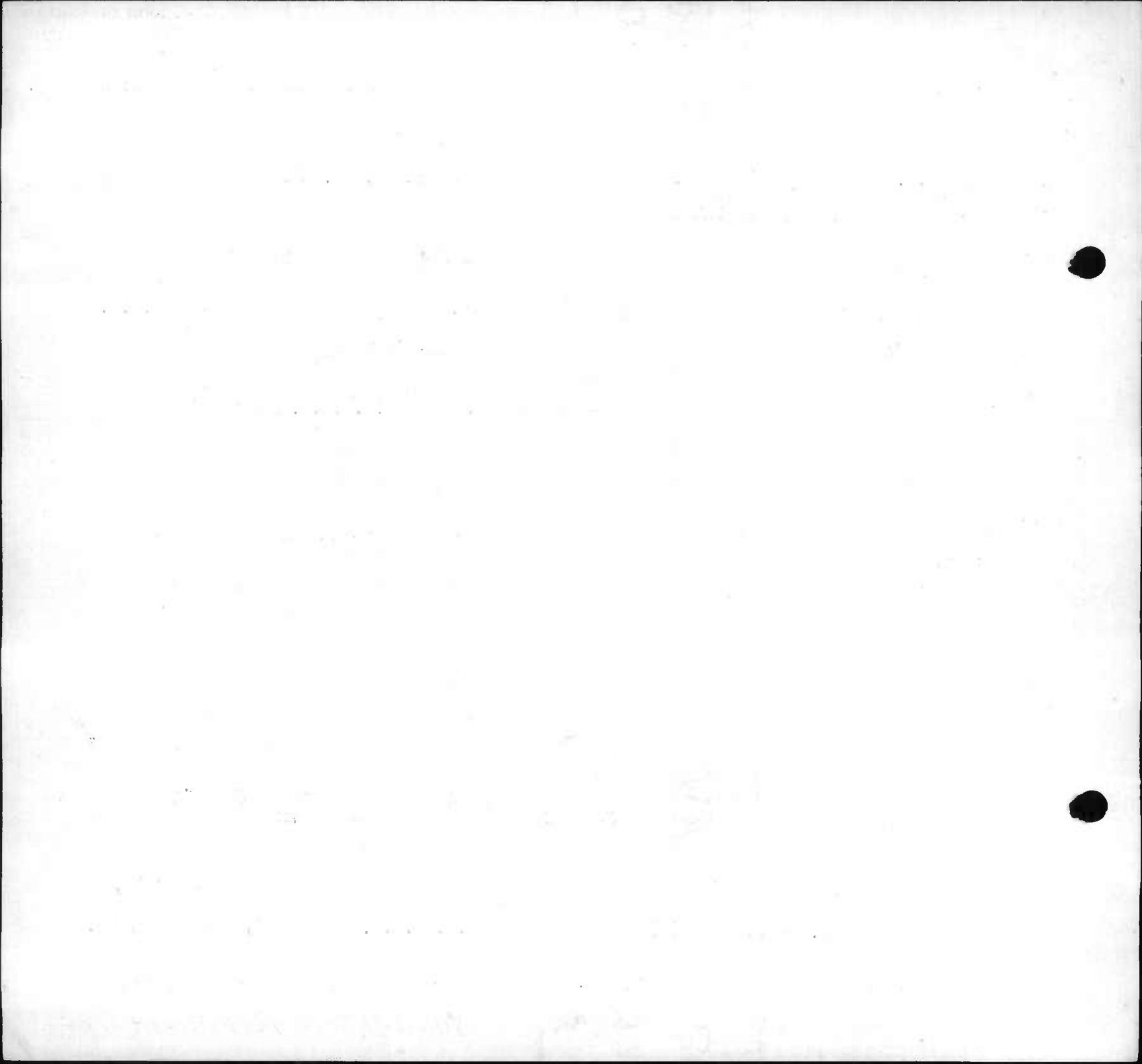
BALTIMORE CITY HEALTH DEPARTMENT				70 6566	REG. NO. _____
BIRTH NO. M-452		70 6566		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BASIL R. MULLINEAUX			2. DATE AND HOUR OF DEATH 6/17/70 3:45 P.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1608 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 629 N. AUGUSTA ST. AVE		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-1-1	9. AGE (in years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retd.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS WILLIAM HALL (friend) 947-4989	
18. 427.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/12/70 19 70 to 6/17/70 19 70 that (I) (we) last saw the deceased alive on 6/17/70 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE LWIN			23B. DATE SIGNED 6/17/70		23C. PHYSICIAN'S NAME (Type) KYI KYI LWIN
24A. BURIAL CREMATION REMOVAL (Specify)			24B. DATE 6-29-70		24C. NAME OF CEMETERY OR CREMATOR ANATOMY BOARD OF MARYLAND
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		
JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	
70 6567		CERTIFICATE OF DEATH		REG. NO. 70 6567	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Eddie Morris		2. DATE AND HOUR OF DEATH 24 June 1970, 2:34 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia B. COUNTY V-43			
FULL NAME OF HOSPITAL OR INSTITUTION U.S. Public Health Service Hospital 3100 Wyman Park Drive Baltimore, Maryland 21211		C. CITY OR TOWN Whitestone, Va. 22578		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-9-14	9. AGE (In years last birth) 55	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deckhand		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eddie Morris		14. MOTHER'S MAIDEN NAME Adlaide Dolby	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 224-12-0415		17. INFORMANT Records U.S.P.H.S. Hospital	
18. 191X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) herniation ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. cerebral edema astrocytoma		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: herniation (B) DUE TO, OR AS A CONSEQUENCE OF: cerebral edema (C) DUE TO, OR AS A CONSEQUENCE OF: astrocytoma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins mins months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XX (this hospital) attended the deceased from May 14 19 70 to June 24 19 70 , that XX (we) last saw the deceased alive on June 24 19 70 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel P. Ward, M.D.				23B. DATE SIGNED June 24, 1970	
23C. PHYSICIAN'S NAME (Type) SAMUEL P. WARD, Surg (R)				23D. ADDRESS U.S. P.H.S. Hospital, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/70		24C. NAME OF CEMETERY OR CREMATORY Mt Vernon Church Cemetery	
24D. LOCATION (City, town, or county) (State) Whitestone VA.					
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. C. March	
25D. ADDRESS 928 E. NORTH Ave					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WYATT MC CARGO

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

6

25

1970

6:49 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

1608

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)
2 wks.If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

4147 Mountwood Rd.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George McCargo

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Dorothy Kelly

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

George McCargo 4147 Mountwood Rd.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Congenital heart disease
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-26-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/27/70

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUN 30 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Wm. C. March

ADDRESS

928 E. North Ave.

70 6569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 70 6569

BIRTH NO.

1. NAME OF DECEASED

(Type or Print) SHEA, GRACE B.

2. DATE AND HOUR OF DEATH

6-26-70

2:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

509 North Carey Street #21223

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12-6-96

9. AGE (In years
last birthday) 73If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wilbert Smallwood

14. MOTHER'S MAIDEN NAME

Jennie

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Records: Baltimore City Hospitals

ADDRESS

4940 Eastern Avenue #21224

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Respiratory Arrest

5 min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Sepsis

3 days.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6-19 1970 to 6-26 1970
that (I) (we) last saw the deceased alive on 6-26 1970 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John R Bredter MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6-26-70

23C. PHYSICIAN'S
NAME (Type)

John R Bredter

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/1/70

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem Park

24D. LOCATION

(City, town, or county)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 30 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

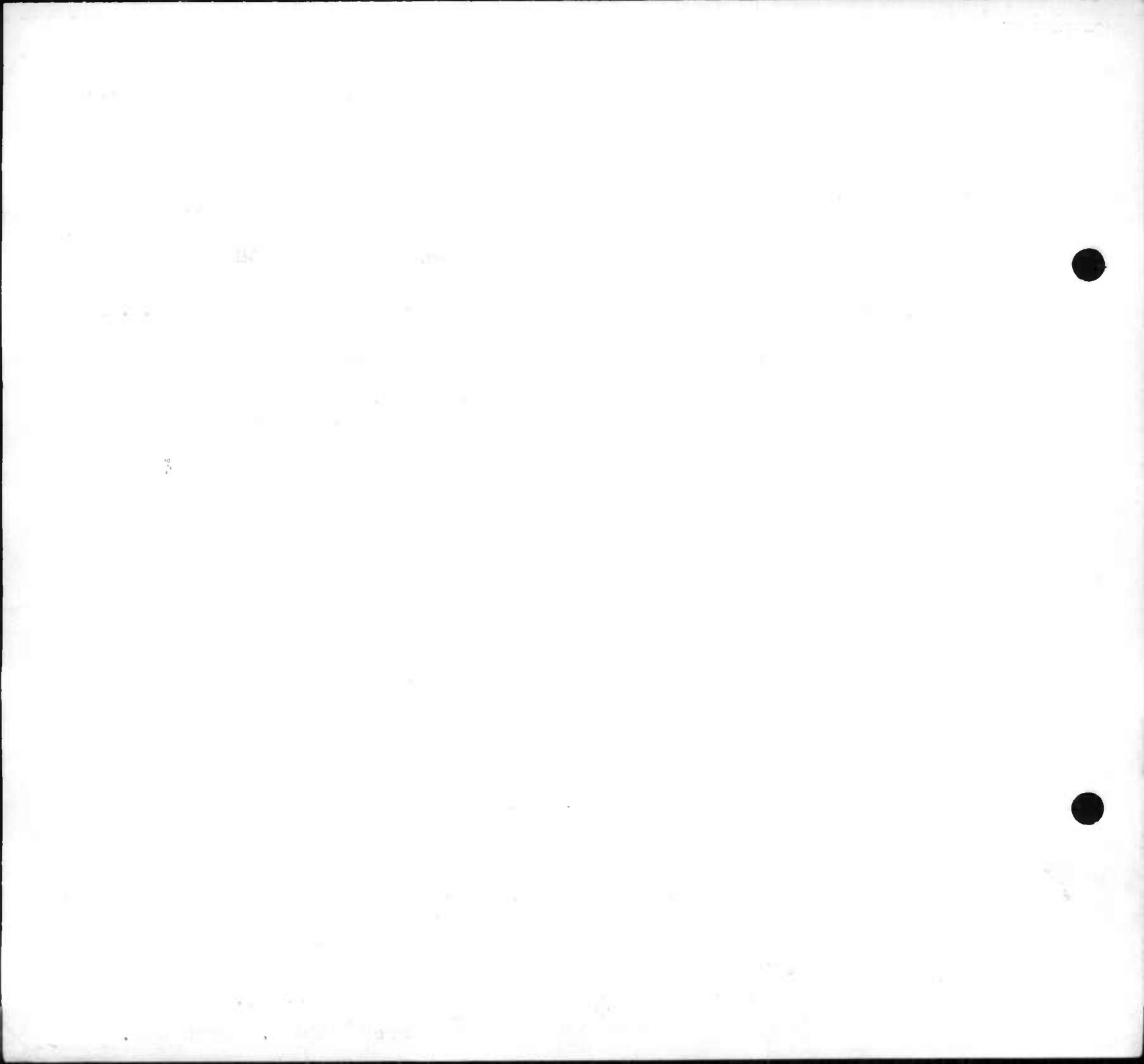
25C. FUNERAL DIRECTOR

Wm C March 928 E. North Ave.

ADDRESS

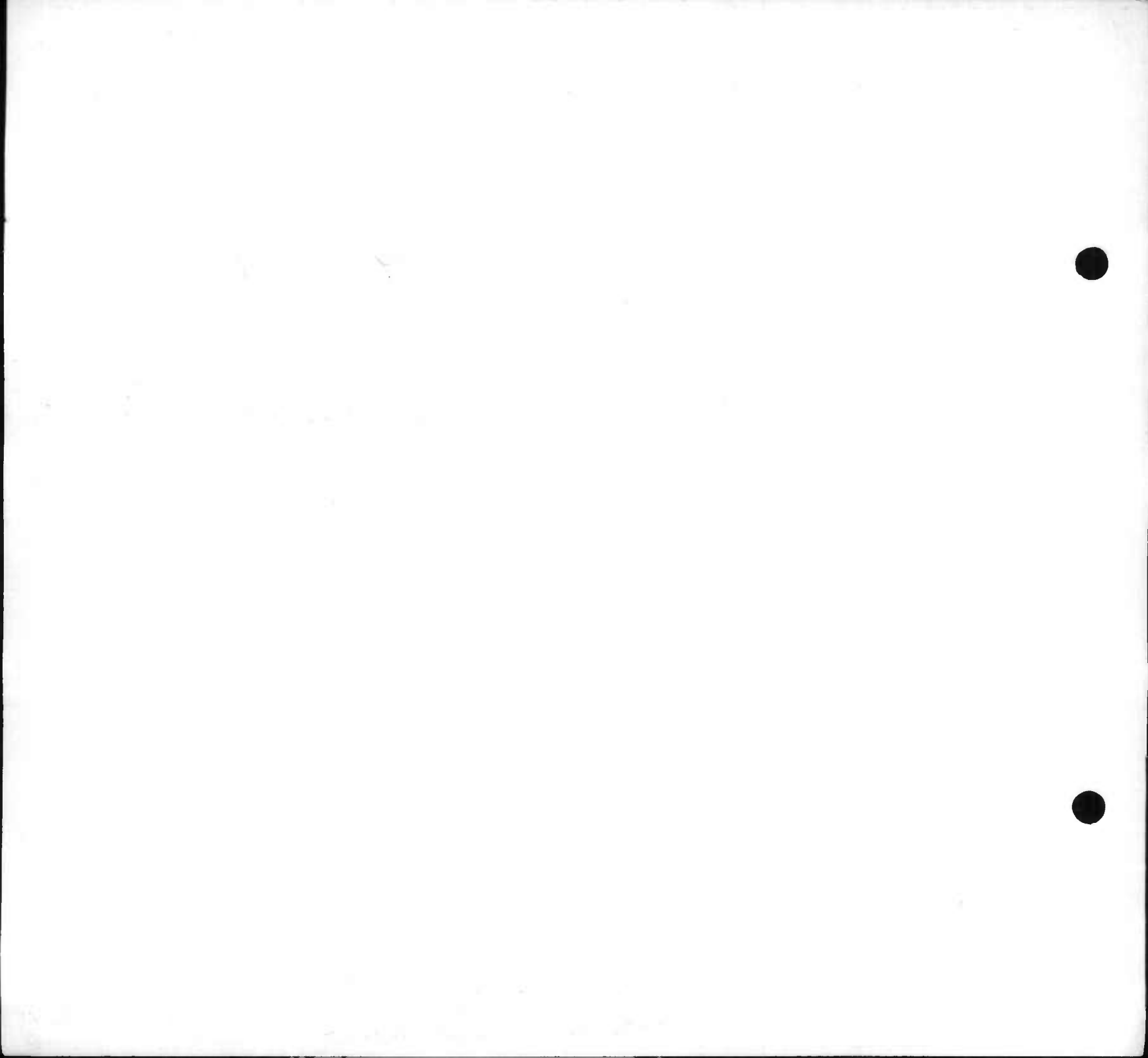
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

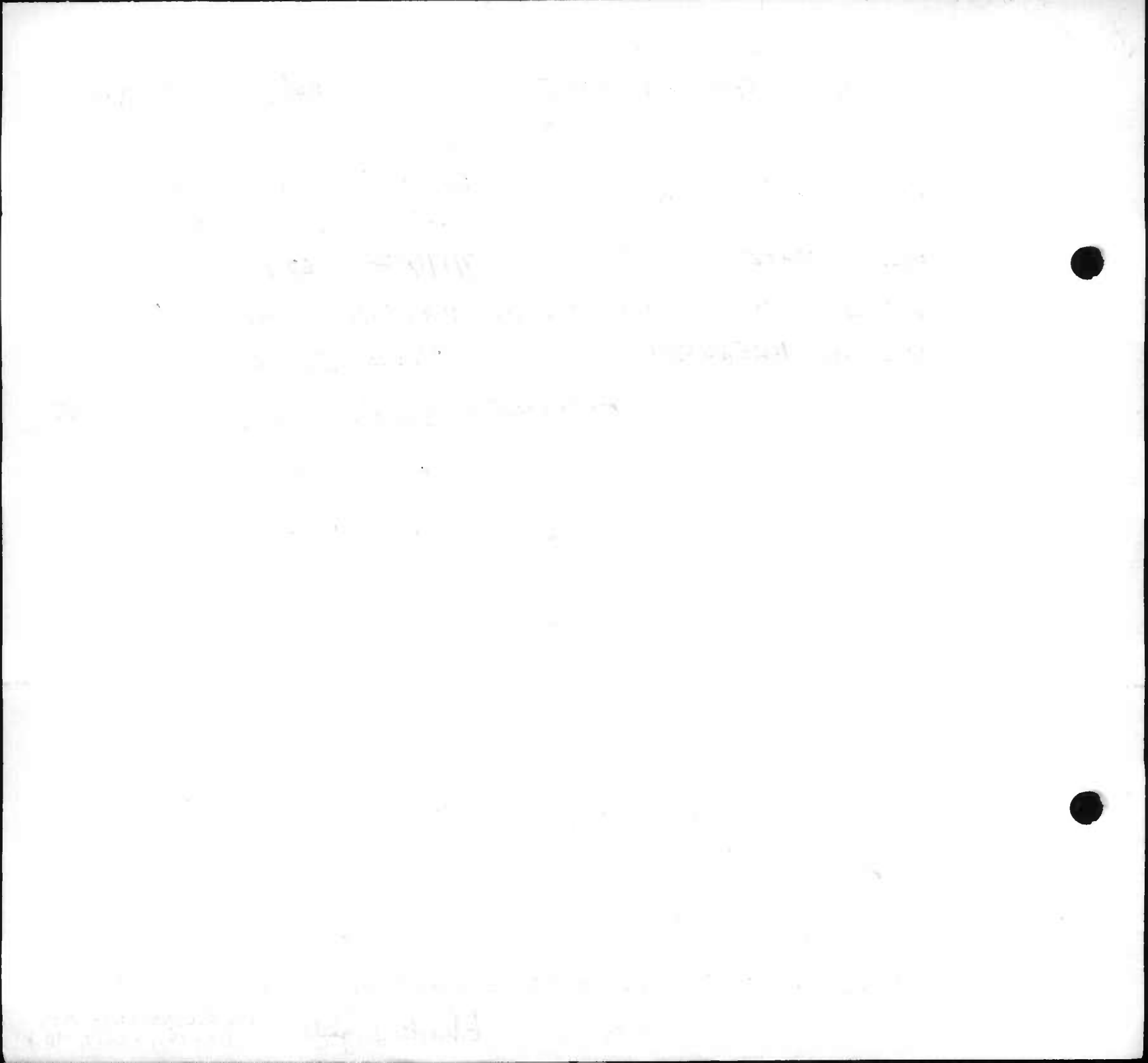
BALTIMORE CITY HEALTH DEPARTMENT				70 6570		REG. NO. 70 6570	
BIRTH NO.				70 6570		70 6570	
1. NAME OF DECEASED (Type or Print) MRS. LILLIAN B. WASIEWSKI				2. DATE AND HOUR OF DEATH 6/27/70 9.35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 201			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 314 S. Chapel Street			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/3/89	9. AGE (In years last birthday) #81	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Michael Braczynski				14. MOTHER'S MAIDEN NAME Helen Cegielski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-18-9862		17. INFORMANT HELEN CEGIELSKI		ADDRESS 2231 BANK ST.	
18. CAUSE OF DEATH 7-41.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Heart failure DUE TO, OR AS A CONSEQUENCE OF: Cardiac decompensation (B) Abdominal aorta aneurysm DUE TO, OR AS A CONSEQUENCE OF: not known (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one week	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 6/25/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/24/70 to 6/27/70 that (I) (we) last saw the deceased alive on 6/27/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE V. Vongvattunyu MD				23B. DATE SIGNED 6/27/70			
23C. PHYSICIAN'S NAME (Type) V. VONGVATTUNYU MD				23D. ADDRESS Bon Secours Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/1/70		24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		24D. LOCATION (City, town, or county) (State) QUINDARY MD	
25A. DATE RECD BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR JOHN WEBER		ADDRESS 401 S. CHESTER	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
70 6571		70 6571		70 6571	
1. NAME OF DECEASED (Type or Print) A KEHURST, MR. WILLIAM, E.			2. DATE AND HOUR OF DEATH 6/24/70 542 AM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CHURCH HOME HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 601		
FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 445 N. CURLEY ST. #21224			E. STREET AND NUMBER		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/1902	9. AGE (In years last birthday) 67 yr.	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME WILLIAM E. AKEHURST		
14. MOTHER'S MAIDEN NAME ANNIE ELLIS			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 705-077865			17. INFORMANT JAMES AKEHURST ELIZABETH AKEHURST		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.) Arteriosclerotic Cardiovascular Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6/10/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/15/70 19 to 6/24/70 19 that (I) (we) last saw the deceased alive on 6/24/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) F. Chorvi			23D. ADDRESS MD CHURCH BALTIMORE		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-27-70		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEMETERY	
24D. LOCATION (City, town, or county) (State) NORTH AVE. + ROSE ST. BALTO., MD.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970			
25B. NAME OF REGISTRAR Robert E. Fahey, M.D.		25C. FUNERAL DIRECTOR Charles J. Geiler			
25D. ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.					



C-0001

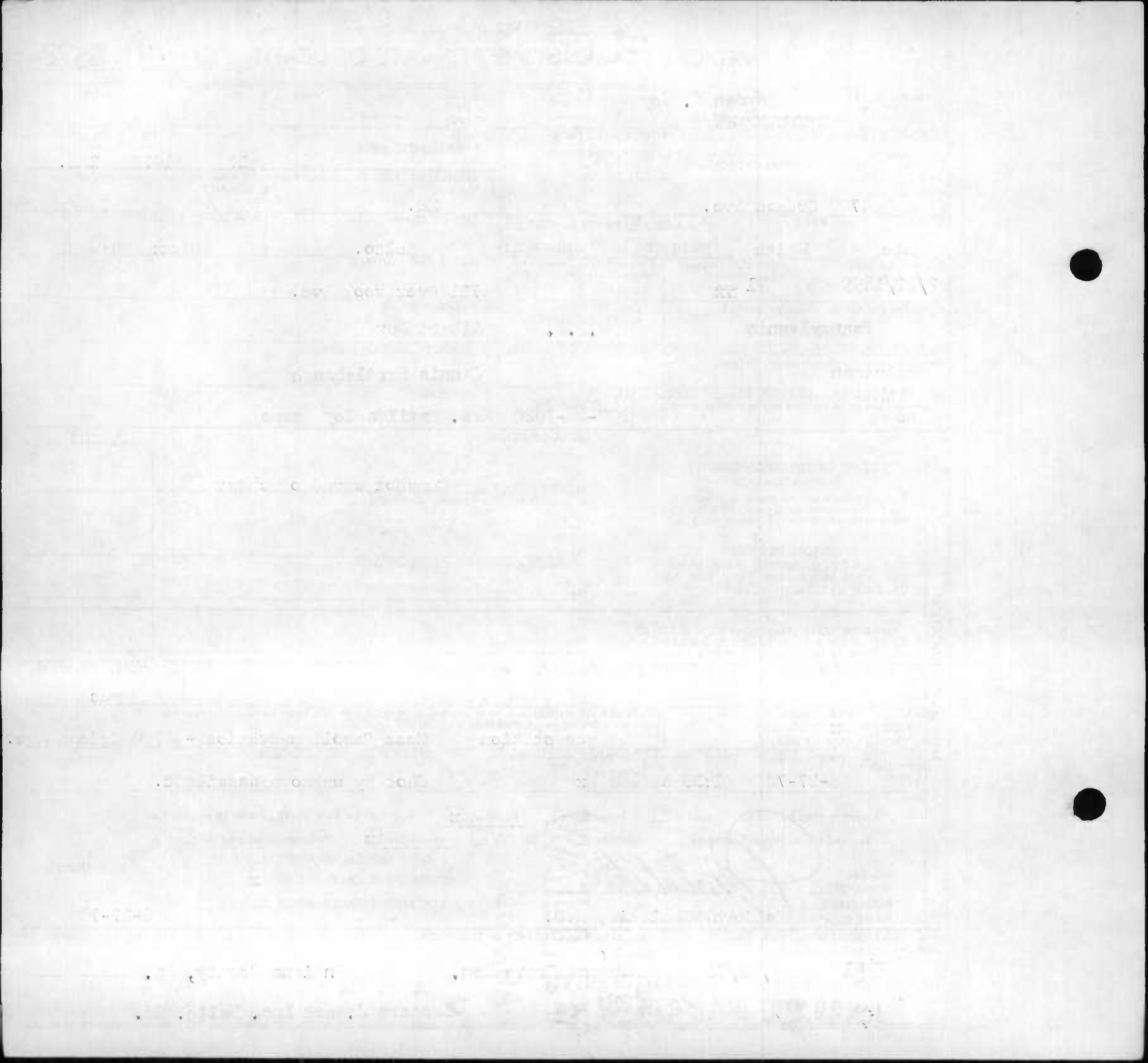
70 6572

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6572

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Royden F. Coy ROYSTON COY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 4700 Erdman Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 27 1970 2 A. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 721 Overbrook Ave.	
9. DATE OF BIRTH 2/22/1899		10. AGE (In years last birthday) 71		11. BIRTHPLACE (State or foreign country) Pennsylvania	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Coy	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Jennie Bartlebaugh	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 200-28-7828		18. INFORMANT ADDRESS Mrs. Matilda Coy same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) gas station		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Hess Gasoline Station - 4700 Erdman Ave.	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 6-27-70 1:35 A.m.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. DATE SIGNED 6-27-70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/70		24C. NAME OF CEMETERY or CREMATORY Spruce Grove Cem.	
24D. LOCATION (City, town, or county) (State) Indiana County, Pa.		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.					



AS 5-460 1

70 6573

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 6573

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SHEELER, LILLIAN MAE

2. DATE AND HOUR OF DEATH

JUNE 26, 1970 5:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40 ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

MARYLAND Baltimore

C. CITY OR TOWN

CATONSVILLE

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

SUMMIT NURSING HOME

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

06 18 1927

9. AGE (in years
last birthday)

73

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

CHARLES JANSEN

14. MOTHER'S MAIDEN NAME

LOUISE ROSE Holston

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213 34 3254

17. INFORMANT

ADDRESS

ST AGNES HOSP RECORDS-BALTO MD 21229

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from JUNE 23 19 70 to JUNE 26 19 70
that (X) (we) last saw the deceased alive on JUNE 26 19 70 and that in (XX) (our) opinion death occurred on the date
and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

BITZAN

EBRAHIMY M.D.

DEGREE

Attending ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

06 26 70

23D. ADDRESS

ST AGNES HOSPITAL CATON & WILKENS AVE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/30/70.

24C. NAME OF CEMETERY OR CREMATORY

Moreland Memorial Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 30 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

406 Edsdale Rd 21229

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

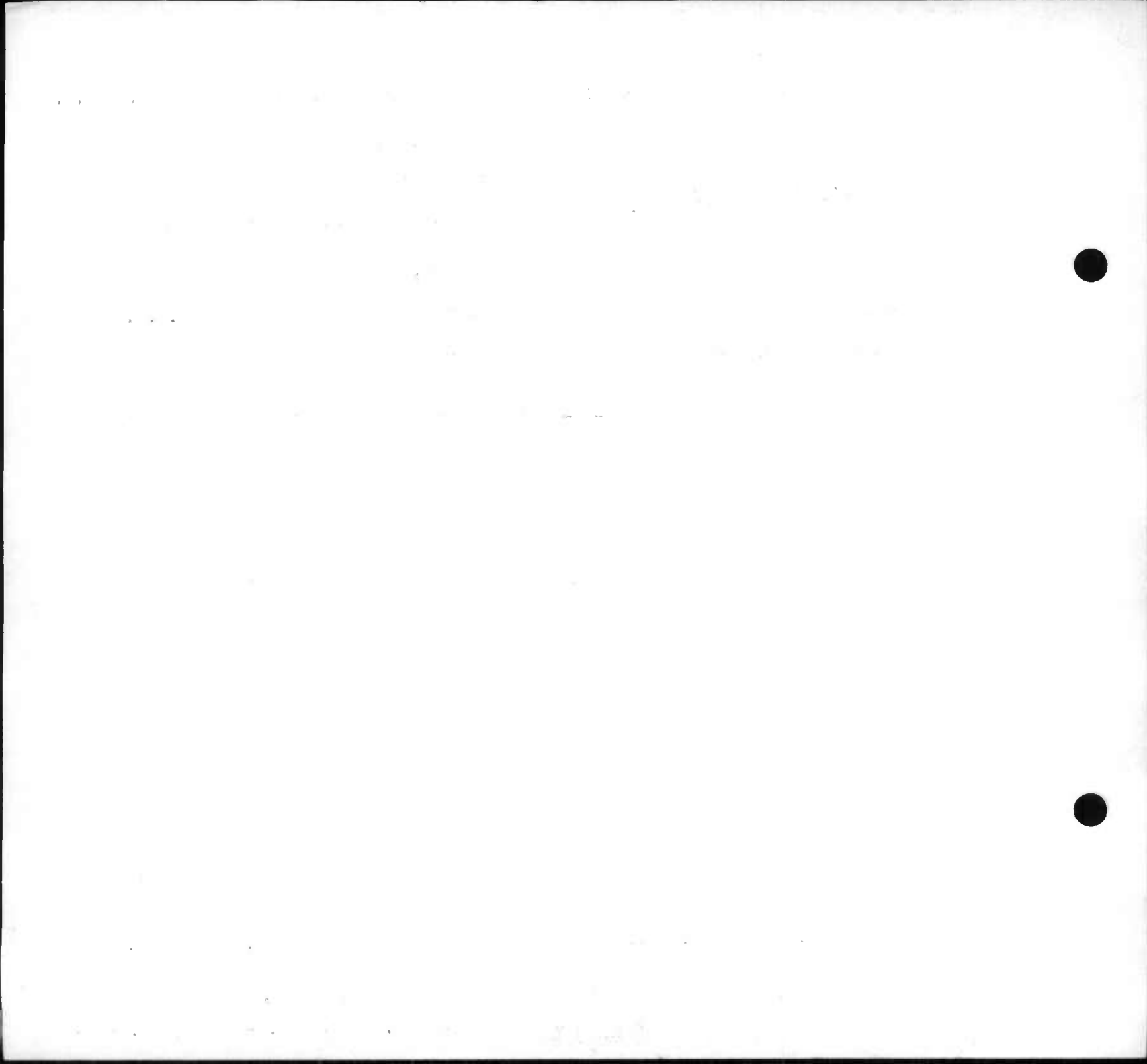
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6574	
70 6574				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) STAMERRO, AGNES -		2. DATE AND HOUR OF DEATH JUNE 26, 1970 12:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MD. B. COUNTY 2745			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3404 GLENMORE AVE.,			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-20-02	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CONSTANZO MUCCI		14. MOTHER'S MAIDEN NAME CARMELLA BONAVEALE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 219-10-1582		17. INFORMANT Santo Stamerro 3404 Glenmore Ave 21214	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia,			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Lung abscess, uremia,			
		(C) obstructive lung disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from MAY 29, 1970 19 to JUNE 26, 1970		that (X) (we) last saw the deceased alive on JUNE 26, 1970 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.	
23A. SIGNATURE A. Shams, M.D.		23B. DATE SIGNED 6-26-70		23C. PHYSICIAN'S NAME (Type) ABDOLLAH SHAMS, M.D.	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-70	
24C. NAME OF CEMETERY or CREMATORY Moreland Memorial		24D. LOCATION (City, town, or county) (State) Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. JUN 30 1970	
24F. NAME OF REGISTRAR Robert E. Taylor, M.D.		24G. FUNERAL DIRECTOR Leonard J. Ruck Inc Balto. Md. 21214		24H. ADDRESS	

Leonard J. Buck Inc. Balto. Md. 21211
Burial 6-29-70 Maryland Memorial Balto. Md.

XXXXXXXXXXXXXXXXXXXX Constance Mucci
XXXXX Bonaville
Santo Stamerio 3404 Glenmore Ave 21211

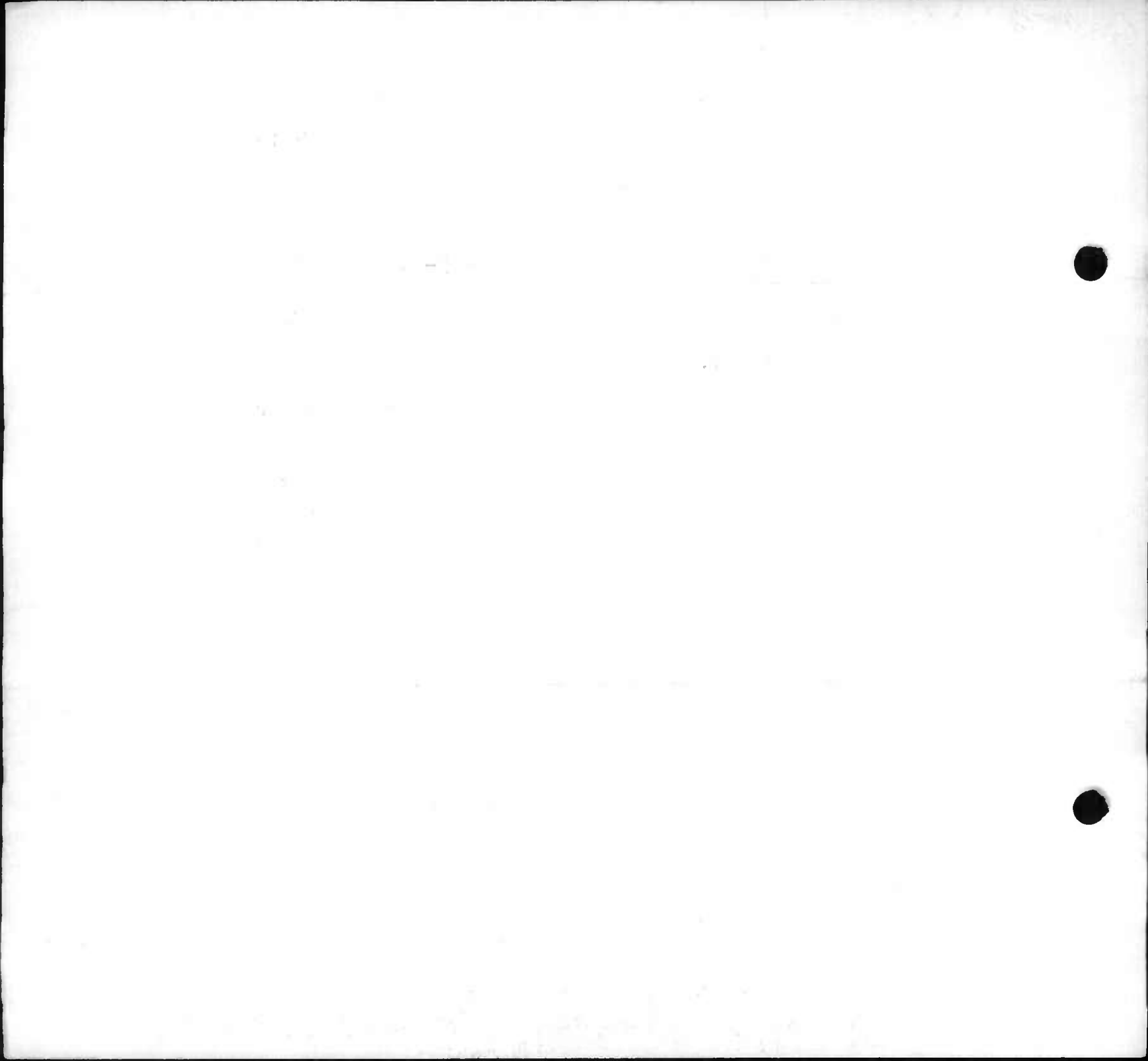
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6575</u>	
BIRTH NO. <u>70 6575</u>					
1. NAME OF DECEASED (Type or Print) <u>MARTHA GAIŁCZEWSKI</u>		2. DATE AND HOUR OF DEATH <u>June 28, 1970</u> <u>9.15 p.m.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 mt. sinai nursing home</u> <u>4613 Psrk Heights Ave.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Waco</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>102 Seventh Ave, Brooklyn Park, 25</u>			
5. SEX <u>female</u>	6. RACE <u>caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 24, 1915</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Stephen Politowicz</u>		14. MOTHER'S MAIDEN NAME <u>Anna ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-5807</u>		17. INFORMANT <u>Mr Thaddaus J Golczewski</u>	
18. <u>398X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral embolism</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Rheumatic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u> <u>Several years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>6/29/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1970</u> to <u>June 28, 1970</u> that (I) (we) last saw the deceased alive on <u>June 26, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dr. Seymour H. Rubin</u>		23B. DATE SIGNED <u>6/29/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Seymour H. Rubin</u>	
23D. ADDRESS <u>5415 Park Heights Ave, Balto, Md.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/2/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. - Balto, Md. - 14</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		70 6576	
70 6576				CERTIFICATE OF DEATH		70 6576	
1. NAME OF DECEASED (Type or Print) <i>Therese Garner</i>				2. DATE AND HOUR OF DEATH <i>6-24-70 8:18 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>THE JOHNS HOPKINS HOSPITAL</i> <i>33</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>PRINCE GEORGE</i> C. CITY OR TOWN <i>FORESTVILLE</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2411 OAK GLEN WAY</i> <i>20028</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-13-61</i>	9. AGE (In years last birthday) <i>9</i>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dependent</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>WILLIAM I. GARNER</i>				14. MOTHER'S MAIDEN NAME <i>MARY DISHARON</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>William I. Garner</i>		ADDRESS <i>2411 Oakgley Way</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				FORESTVILLE, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <i>Pulmonary Edema - Cardiovascular</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Post. Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>of Anter.</i>						<i>36 hrs -</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>6-23-70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Coronary artery</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-23-1970</i> to <i>6-24-1970</i> that (I) (we) last saw the deceased alive on <i>6-24-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>A. G. Trevilla</i> M.D.				23B. DATE SIGNED <i>6-24-70</i>			
23C. PHYSICIAN'S NAME (Type) <i>Antonio Gonzalez Trevilla</i> M.D.				23D. ADDRESS <i>Johns Hopkins Hospital - Balto. Md 21205</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>6/27/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Clinton Pr. Geo. Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Tabor, R.A.</i>		25C. FUNERAL DIRECTOR <i>Robert E. Wilhelm Funeral Home</i>		ADDRESS <i>4308 Suitland Rd. S.E. - Suitland, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		70 6577		70 6577	
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Fannie Young		6/22/70 9 ³⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Md. Gen Hosp		Md. Balto.			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Towson			
		D. STREET ADDRESS (If rural, give location)			
		Dulaney Towson Nursing Home			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W	W	2/17/83	87	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker		Own Home		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Walter Clifford Beall			Adelaide W. Milstead		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Sister In law Ethel Fisher 1415 Tenbury	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
15791		(A) Carcinomatosis		?	
ANTECEDENT CAUSES		(B) Ca of Pancreas		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
6/17/70		Ca		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/14/70 19 to 6/22/70 19, that (I) (we) last saw the deceased alive on 6/22/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DeWitt E. Kemp				6/22	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DeWitt Kemp				3602 Keler Rd	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		June 25, 1970		Ivy Hill Cemetery	
				Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUN 30 1970		Robert E. Fisher, M.D.		John Burns' Sons, Towson, Md.	

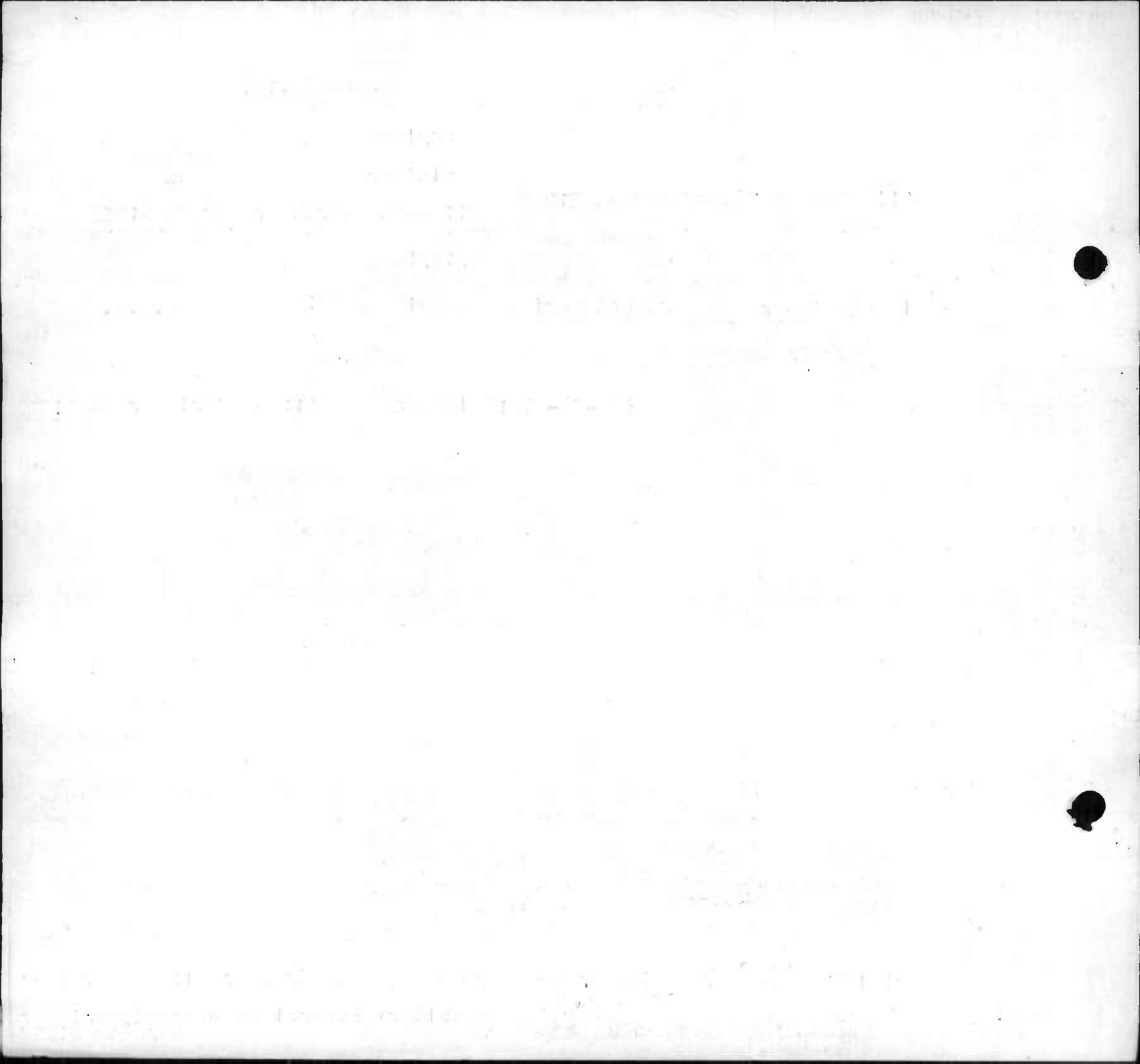
Called Nursing Home
Prior Address WAS
3939 Roland Ave 21211.

Entered Nursing home 4/28/70.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

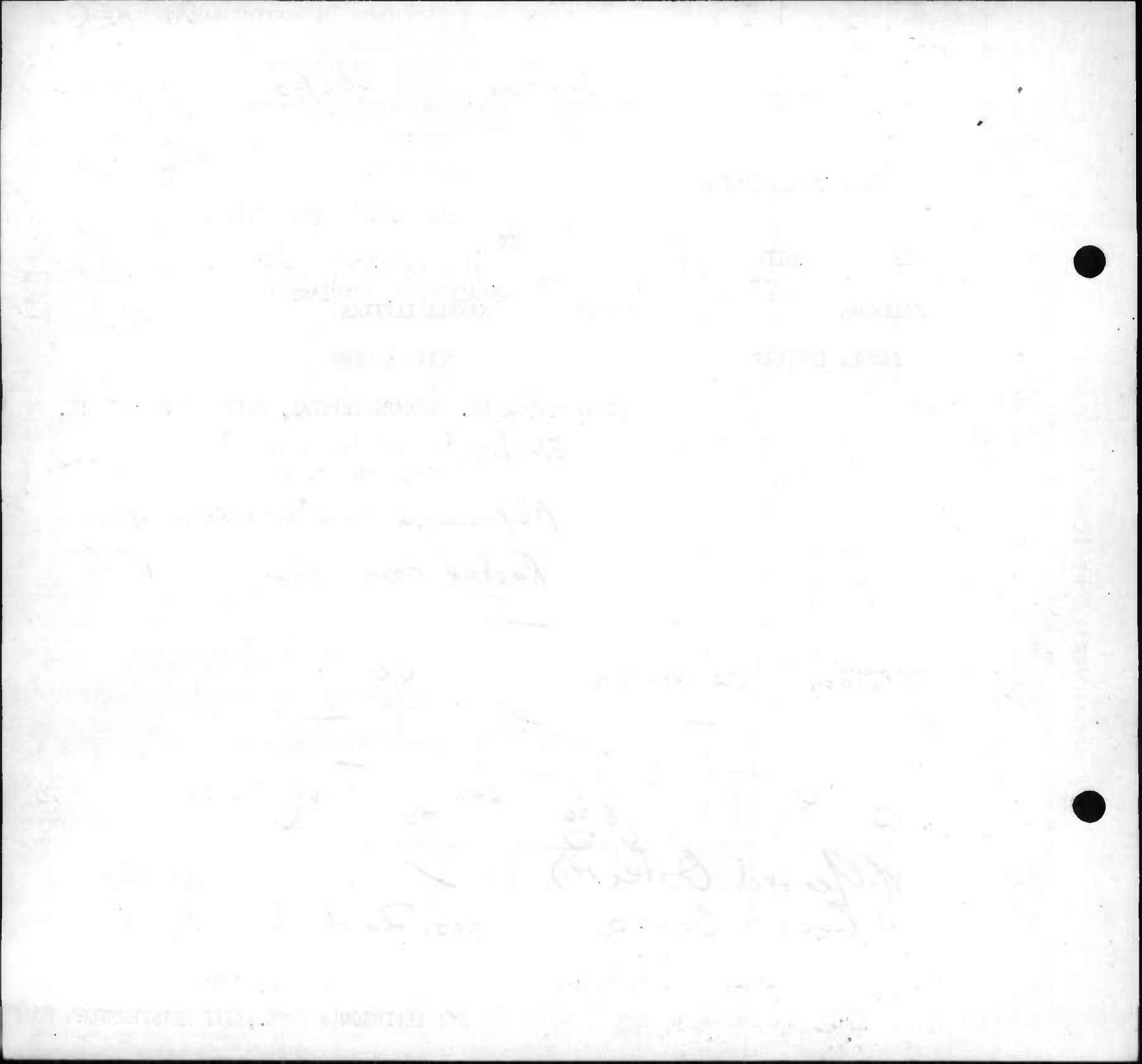
BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>70 6578</u>
BIRTH NO. <u>70 6578</u>						M.
1. NAME OF DECEASED (Type or Print) ANDREW FREEMAN			2. DATE AND HOUR OF DEATH June 25, 1970			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 211 South Stricker Street 21223			A. STATE Maryland B. COUNTY 1902			
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 211 South Stricker Street 21223			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1896	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Engineer		10B. KIND OF BUSINESS OR INDUSTRY Merchant Marine		11. BIRTHPLACE (State or foreign country) Latvia		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Mack Freeman		14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 552-34-2751		17. INFORMANT ADDRESS Alta Freeman 211 So Stricker St 21223		
18. <u>412.41 x 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterior cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anterior cardiovascular disease (B) Generalized arteriosclerosis (C) Diabetes mellitus			
19A. DATE OF OPERATION 6/22/70			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes mellitus			
20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/22/70</u> to <u>6/25/70</u> and that (I) (we) last saw the deceased alive on <u>6/22/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <i>John J. Kudirka</i>			23B. DATE SIGNED 6/26/70			
23C. PHYSICIAN'S NAME (Type) J. KUDIRKA			23D. ADDRESS 2151 W. Chesapeake Ave Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70		24C. NAME OF CEMETERY or CREMATORY Pine Grove Church Cem.		
24D. LOCATION (City, town, or county) (State) Mt Airy, Carroll Co, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		
25C. FUNERAL DIRECTOR Walters Funeral Home		25D. ADDRESS Pratt & Stricker Streets 21223				



FUNERAL DIRECTOR: IMPORTANT

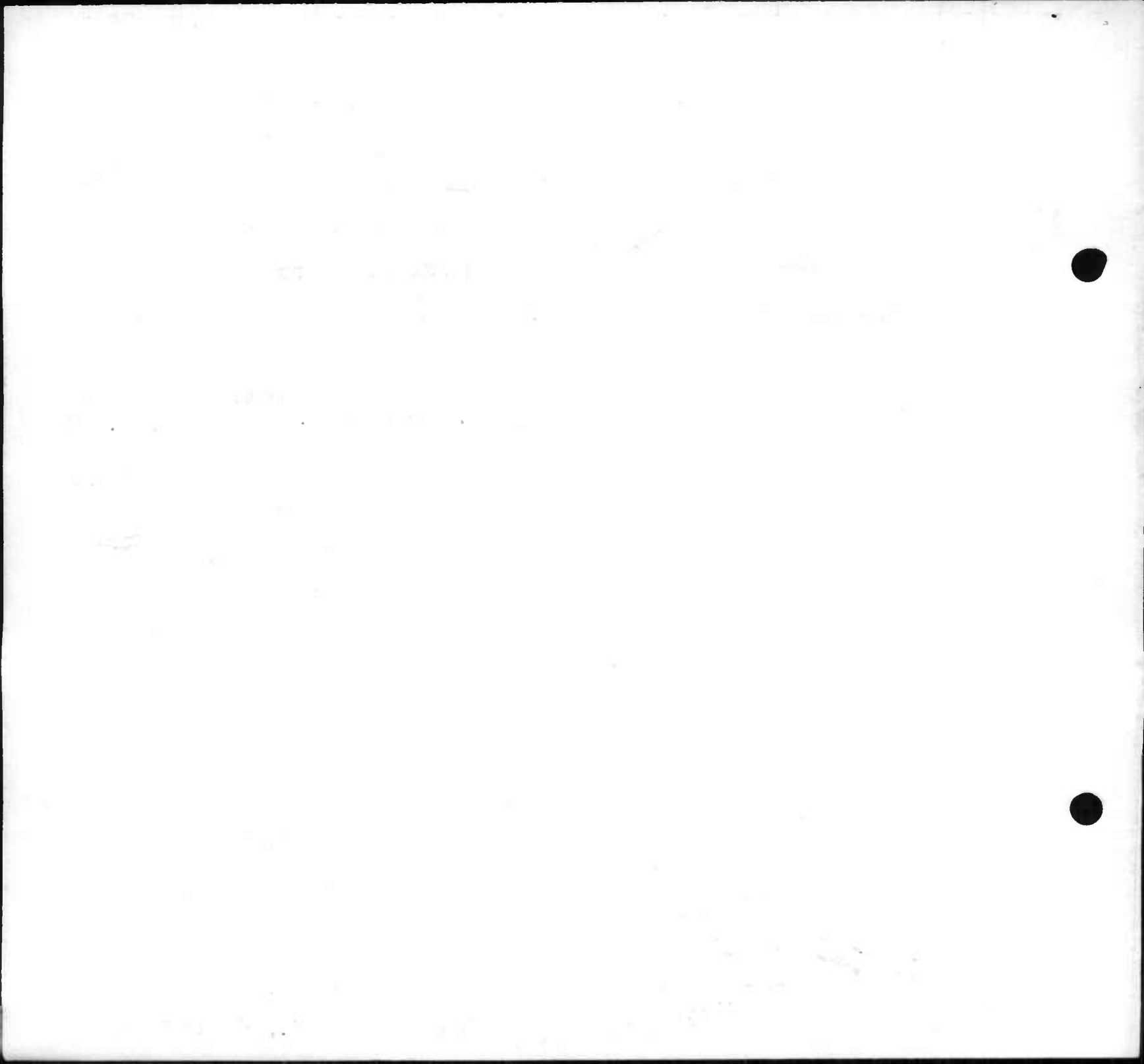
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
L-131 70 6579					REG. NO. 70 6579				
BIRTH NO.					1. NAME OF DECEASED (Type or Print) FRANK LEVITAS				
2. DATE AND HOUR OF DEATH 6/26/70 11 30 A.M.					3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
FULL NAME OF HOSPITAL OR INSTITUTION JEWISH CONVALESCENT HOME					(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE					C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER 2550 RELIM ROAD #21209									
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14 1910		9. AGE (In years last birthday) 60 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN					10B. KIND OF BUSINESS OR INDUSTRY RETAIL				
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME SAMUEL LEVITAS					14. MOTHER'S MAIDEN NAME YETTA SCHERR				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 219-01-7192				
17. INFORMANT MR. LEONARD LEVITAS, 6716 LAURELWOOD AVE. #9					ADDRESS				
18. 154.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Electrolyte imbalance and dehydration					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Abdominal carcinomatosis					4 mos				
(B) DUE TO, OR AS A CONSEQUENCE OF: Rectal carcinoma					approx 18 mos				
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION approx 10/4/1969					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA RECTUM				
20A. AUTOPSY? (Yes or No) NO					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —									
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) —					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR? —									
22. I certify that (1) (this hospital) attended the deceased from 6-1 1965 to 6-26 1970 , that (1) (we) last saw the deceased alive on 6-26 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE H. Gerard Oster MD					23B. DATE SIGNED 6/26/70				
23C. PHYSICIAN'S NAME (Type) H. GERARD OSTER					23D. ADDRESS 6821 Reisterstown Road				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 6-28-70				
24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL					24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970					25B. NAME OF REGISTRAR Robert E. Fisher				
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					ADDRESS				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-440 70 6580		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		70 6580	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SAMUEL GARELL		JUNE 25 1970 4:14 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI Hospital of BALTO. INC			A. STATE MARYLAND B. COUNTY BALTIMORE 5300		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
			E. STREET AND NUMBER 8818 SIGRID ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY WHOLESALE & RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME AARON GARELL			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212-10-2479		
17. INFORMANT MRS. HANNAH GARELL, RANDALLSTOWN, MD. 21133			ADDRESS 8818 SIGRID ROAD		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCT (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) DIABETES MELLITUS -		
19. DATE OF OPERATION 6-19-70			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PROSTATIC HYPERTROPHY		
20A. AUTOPSY? (Yes or No) NO			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6-17-1970 to 6-25-1970 that (I) (we) last saw the deceased alive on 6-25-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leslie Abramowitz M.D.			23B. DATE SIGNED 6-25-70		
23C. PHYSICIAN'S NAME (Type) Leslie Abramowitz M.D.			23D. ADDRESS SINAI Hospital of BALTO. INC.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-28-70		24C. NAME of CEMETERY or CREMATORY BNAI ISRAEL	
24D. LOCATION BALTIMORE, MARYLAND		24E. CITY, town, or county (State)			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
ADDRESS					



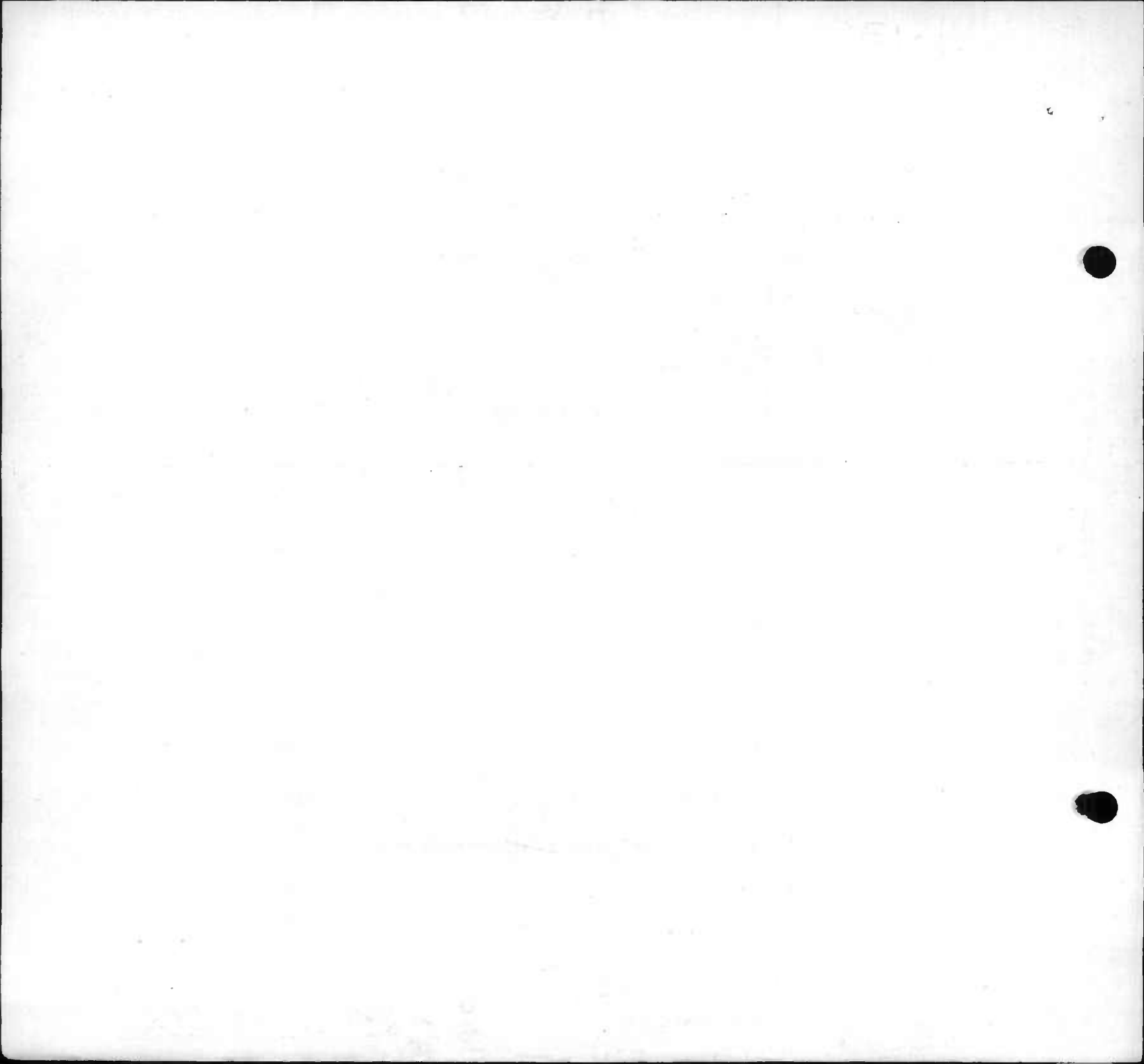
CERTIFICATE OF DEATH

REG. NO. 70 6581

BIRTH NO. 70 6581		2. DATE AND HOUR OF DEATH 6/27/70 1:00 P.M.	
1. NAME OF DECEASED (Type or Print) Samuel A Leibowitz		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-10-10 9. AGE (In years last birthday) 60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) NY	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Julius Leibowitz		14. MOTHER'S MAIDEN NAME Rose Liebowitz	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 065-01-8947	
17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224		ADDRESS	
18. 172.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Malignant Melanoma 2 yrs. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (This hospital) attended the deceased from 6/1/70 to 6/27/70, that (H) (we) last saw the deceased alive on 6/27/70 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE John Neefe MD		23B. DATE SIGNED 6/27/70	
23C. PHYSICIAN'S NAME (Type) John Neefe M.D.		23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70	
24C. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		24D. LOCATION (City, town, or county) (State) New York New York	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Sol [Signature]		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6582	
BIRTH NO. 5-200 70 6582				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ALBERT SAKS			2. DATE AND HOUR OF DEATH JUNE 24, 1970 11:30 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2803 MANHATTAN AVENUE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2803 MANHATTAN AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1906	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY PAPER MILL SUPPLIES		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME HYMAN SAKS			14. MOTHER'S MAIDEN NAME LENA BERNSTEIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. BETTY SAKS, 2803 MANHATTAN AVENUE #15	
18. 4-10-9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1969 to June 24, 1970 , that (I) (we) last saw the deceased alive on March 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David D. Miller				23B. DATE SIGNED June 24, 1970	
23C. PHYSICIAN'S NAME (Type) DAVID MILLER				23D. ADDRESS 9115 REISTERSTOWN ROAD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-26-70		24C. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970			
25B. NAME OF REGISTRAR Robert E. Miller		25C. FUNERAL DIRECTOR GOLD LEVINSON & BROS., 6010 REISTERSTOWN ROAD			

THE UNIVERSITY OF

OF THE STATE OF

NEW YORK

IN SENATE

JANUARY 10, 1900

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

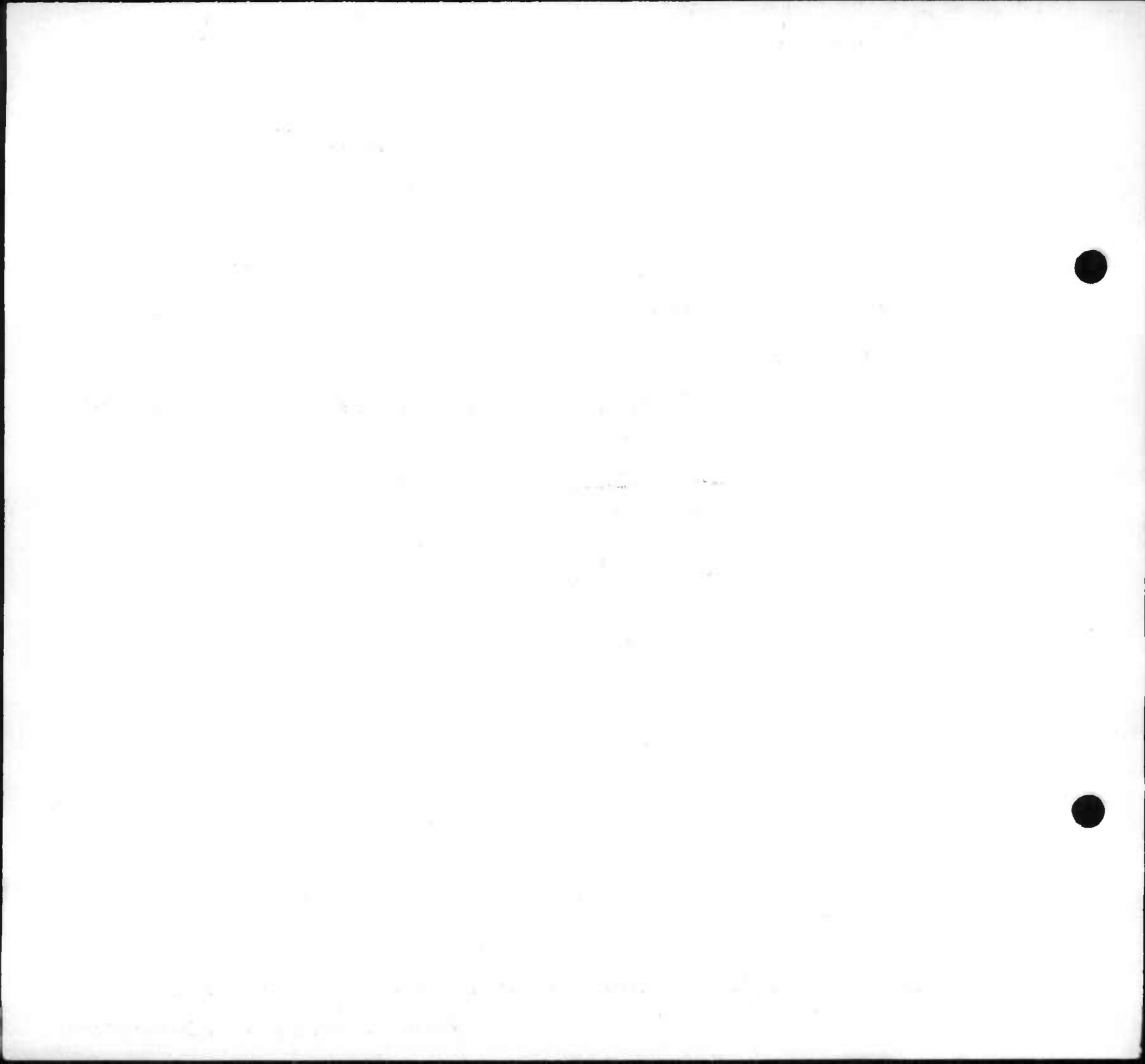
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 6583	
BIRTH NO. L-110 70 6583		1. NAME OF DECEASED (Type or Print) LIBOV HILDA					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE				2. DATE AND HOUR OF DEATH 6/27/1970 5:40 P.M.			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND. B. COUNTY 2730				C. CITY OR TOWN BALTIMORE			
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 6402 BLRAY Dr. 21209			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/1907		9. AGE (In years last birthday) 68.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Shapiro				14. MOTHER'S MAIDEN NAME Rachel ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Irving Libov ADDRESS 6402 Elray Drive # 15		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.41+250.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH (A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: OR PULMONARY EMBOLISM (B) ASCVD and SURGERY. DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus, Possible Malignancy of Lung.							
19A. DATE OF OPERATION 6/24/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ATELECTASIS (R) Middle Lobe		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/3 1970 to 6/27 1970 that (I) (we) lost saw the deceased alive on 6/27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				M. D. DEGREE <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6/27/1970	
23C. PHYSICIAN'S NAME (Type) ANDREAS A. PETSAS M.D.				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 28/70		24C. NAME OF CEMETERY OR CREMATORY Shaarei Tfiloh, Windsor Mill Road		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.A.		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Road			

Elray Dr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-366 70 6584		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6584	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Citraro, Carmelo</u>		2. DATE AND HOUR OF DEATH <u>June 27, 1970</u> <u>4:20 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived - If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>University of Maryland Hospital</u>		A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>10 Fire Oak Court</u>	
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/85</u>	9. AGE (In years last birthday) <u>84</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Ugo Citraro</u>		14. MOTHER'S MAIDEN NAME <u>unk.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>216-03-0653</u>		17. INFORMANT ADDRESS <u>Mr. August Citraro, 10 Fire Oak Court, 21030</u>	
18. <u>403 XI</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Apidosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>chronic nephrosclerosis + pyelonephritis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examled)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1970</u> to <u>June 27, 1970</u> that (I) (we) last saw the deceased alive on <u>June 27, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard W. Mellinger MD</u>		23B. DATE SIGNED <u>June 27, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Dr. Borges - Attending Phys.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/30/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Mem. Gardens</u>	
24D. LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1970</u>		25B. NAME OF REGISTRAR <u>Joseph N. Zannino</u>	
25C. FUNERAL DIRECTOR <u>Joseph N. Zannino</u>		25D. ADDRESS <u>263 S. Conkling Street</u>			

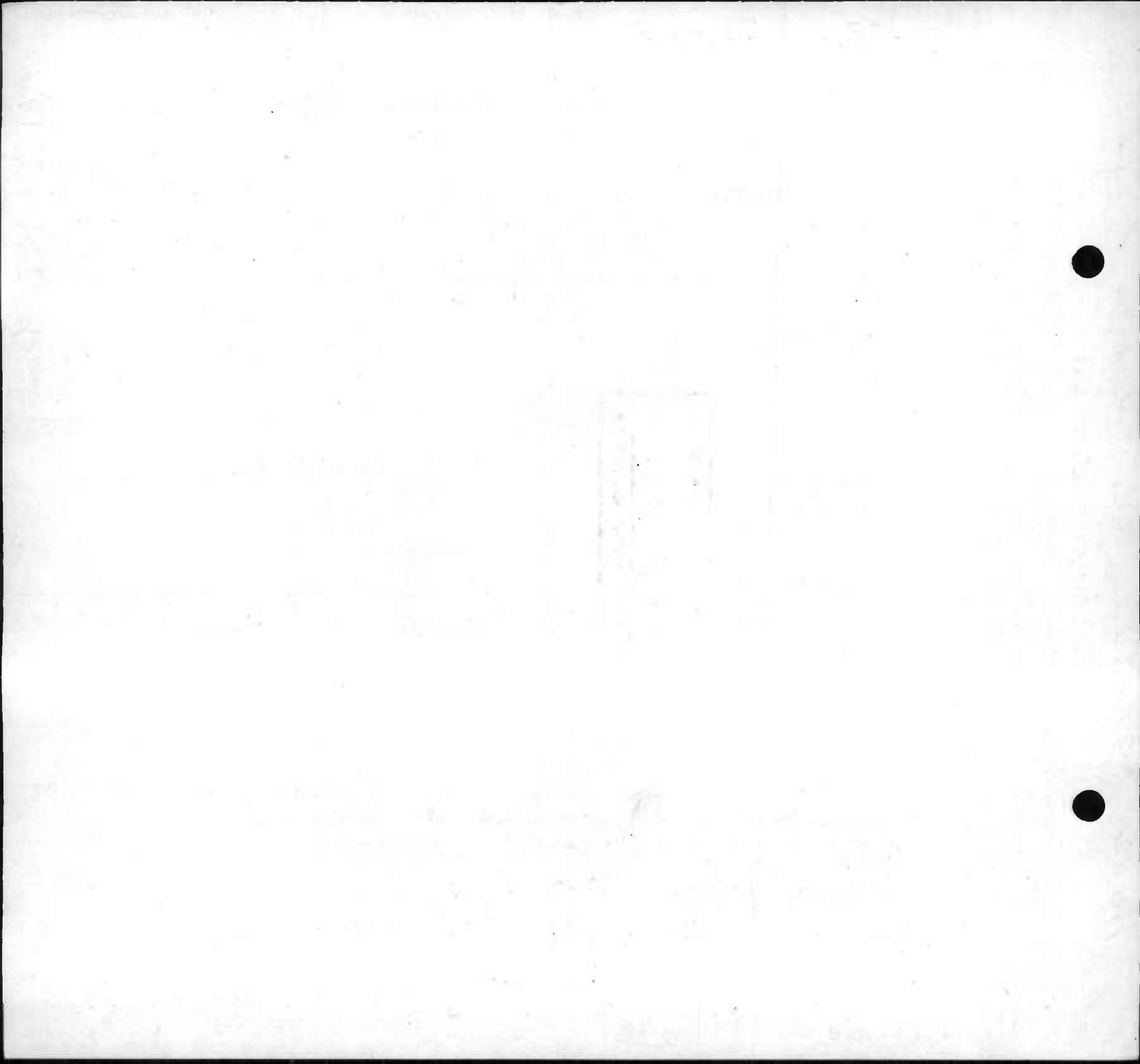


medical examiner - consented on Deagon's

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6585	
BIRTH NO. 3-530 70 6585				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CHARLES E SMITH			2. DATE AND HOUR OF DEATH 6-27-70 9:05 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2021 West Mulberry Street Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 2001 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2021 West Mulberry Street		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-04	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William E. Smith			14. MOTHER'S MAIDEN NAME Jennie Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-05-8373		17. INFORMANT ADDRESS Mary Clark 1926 W. Lexington St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) 19A. DATE OF OPERATION Oct 1969 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Lung 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			CAUSE OF DEATH Carcinoma of the lung (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Congestive Heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1967 to June 27, 1970, that (I) (we) last saw the deceased alive on June 24, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Benigno R. Lazaro M.D.				23B. DATE SIGNED 6-29-70	
23C. PHYSICIAN'S NAME (Type) BENIGNO R. LAZARO M.D.				23D. ADDRESS 59 Dandak Ave. Balto Md 21222	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-1970		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970			
25B. NAME OF REGISTRAR Marshall W. Jones, Jr.		25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-13270 6586		BALTIMORE CITY HEALTH DEPARTMENT		70 6586	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) MARY E. LOFTUS		2. DATE AND HOUR OF DEATH 6/28/70 8:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 105			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 426 S. PATTERSON PARK AVE.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/10/09	9. AGE (In years last birthday) 60
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOHN T. TRACY		14. MOTHER'S MAIDEN NAME MARY MARRET			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-36-2002		17. INFORMANT ADDRESS Gordon Loftus 426 S. Patterson Park Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca of lung and liver (B) 1st carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/21/70 19 to 6/28/70 19 that (I) (we) last saw the deceased alive on 6/28/70 19 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Manuela Ribeiro, M.D.		23B. DATE SIGNED 6/29/70		23C. PHYSICIAN'S NAME (Type) MANUELA RIBEIRO, M.D.	
23D. ADDRESS Mercy Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-1970		24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Ave.	

100-443887-100

[Faint handwritten notes at the bottom of the page]

G-145

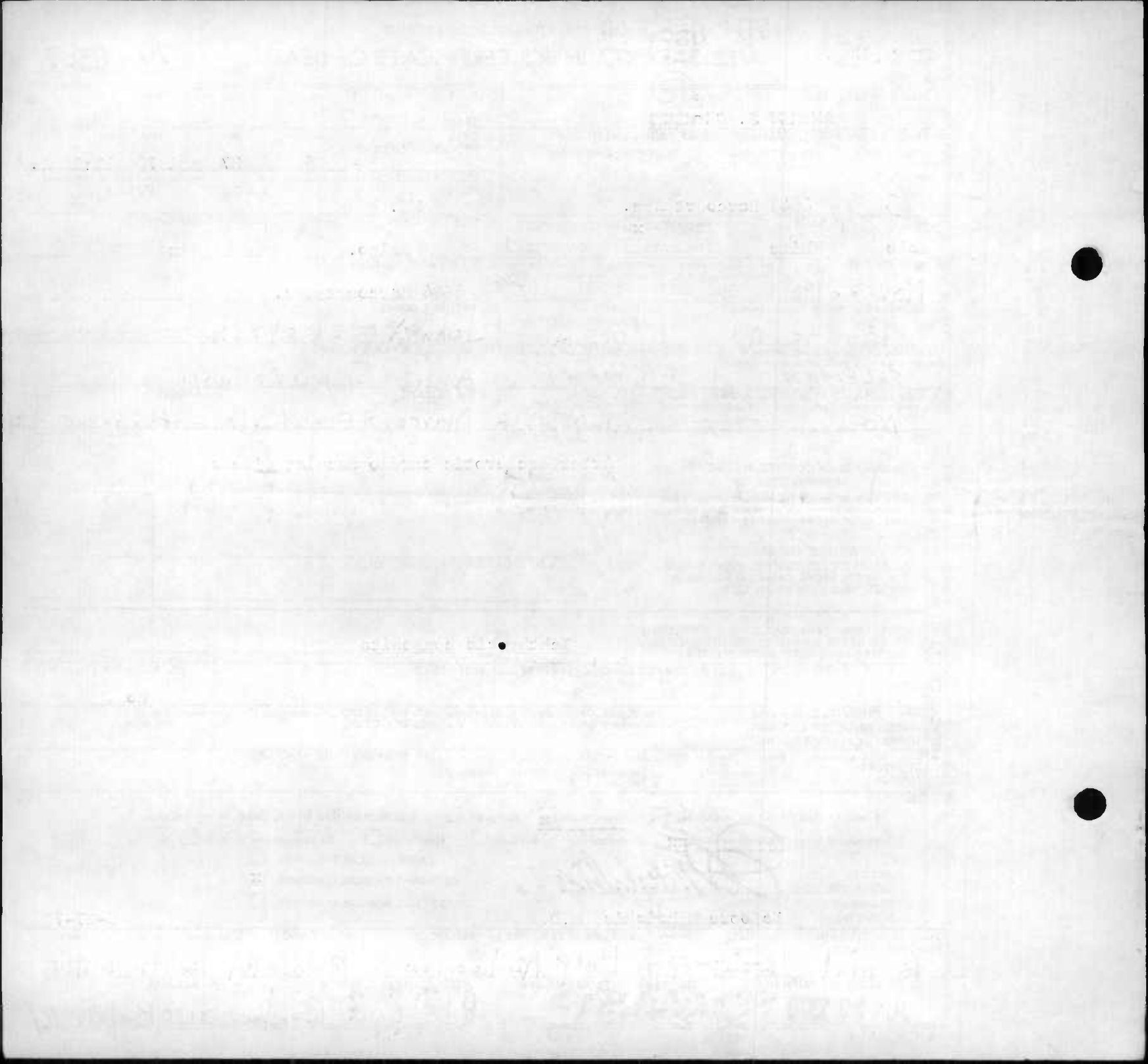
70 6587 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6587

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANDREW J. GEDELEIN				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4644 Harcourt Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour 6 26 1970 12:10 AM			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Nov. 26 1901				10. AGE (In years lost birthday) 69		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John A. Gebelstein		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2741	
15. MOTHER'S MAIDEN NAME Anna Schuerman				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 216053123A				18. INFORMANT ADDRESS Margaret E. Gebelstein 4644 Harcourt Rd			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Ichthyosis congenita				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Ichthyosis congenita							
22A. DATE OF OPERATION 0				22B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? no				22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) 6-29-70			
22E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Holy Redeemer				22F. HOW DID INJURY OCCUR? WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-27-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 6-29-70			
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer				24D. LOCATION (City, town, or county) (State) Bolair Rd Balto. 6 Md.			
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR Robert E. Taylor, M.D.				ADDRESS 7110 Bolair Rd			



70 6588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

70 6588

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Clara Lucille Brown

2. DATE AND HOUR OF DEATH

6/26/70

1 9 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

Maryland, Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

139 Winters Lane 21228 005

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1-6-26

9. AGE (In years
last birthday)

44

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward Smith

14. MOTHER'S MAIDEN NAME

Elizabeth Smith

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

215-32-2144

17. INFORMANT

Herman Brown
BCH-Records

ADDRESS

4940 Eastern Avenue
Baltimore, Maryland 21224

18. 343.11

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

SEPSIS

5 mo.

(B) MULTIPLE DEUBIN
DUE TO, OR AS A CONSEQUENCE OF:

1 yr

(C) SPASTIC PARAPLEGIA UNK 90% 13 yr

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 11/70 to 6/26 19 70
that (H) (we) last saw the deceased alive on 6/26 19 70 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John Neefe MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6/26/70

23C. PHYSICIAN'S
NAME (Type)

John Neefe

MD

DEGREE

23D. ADDRESS

BCH- 4940 Eastern Avenue
Baltimore Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial 7/1/70

Baltimore National

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUN 30 1970

25B. NAME OF REGISTRAR

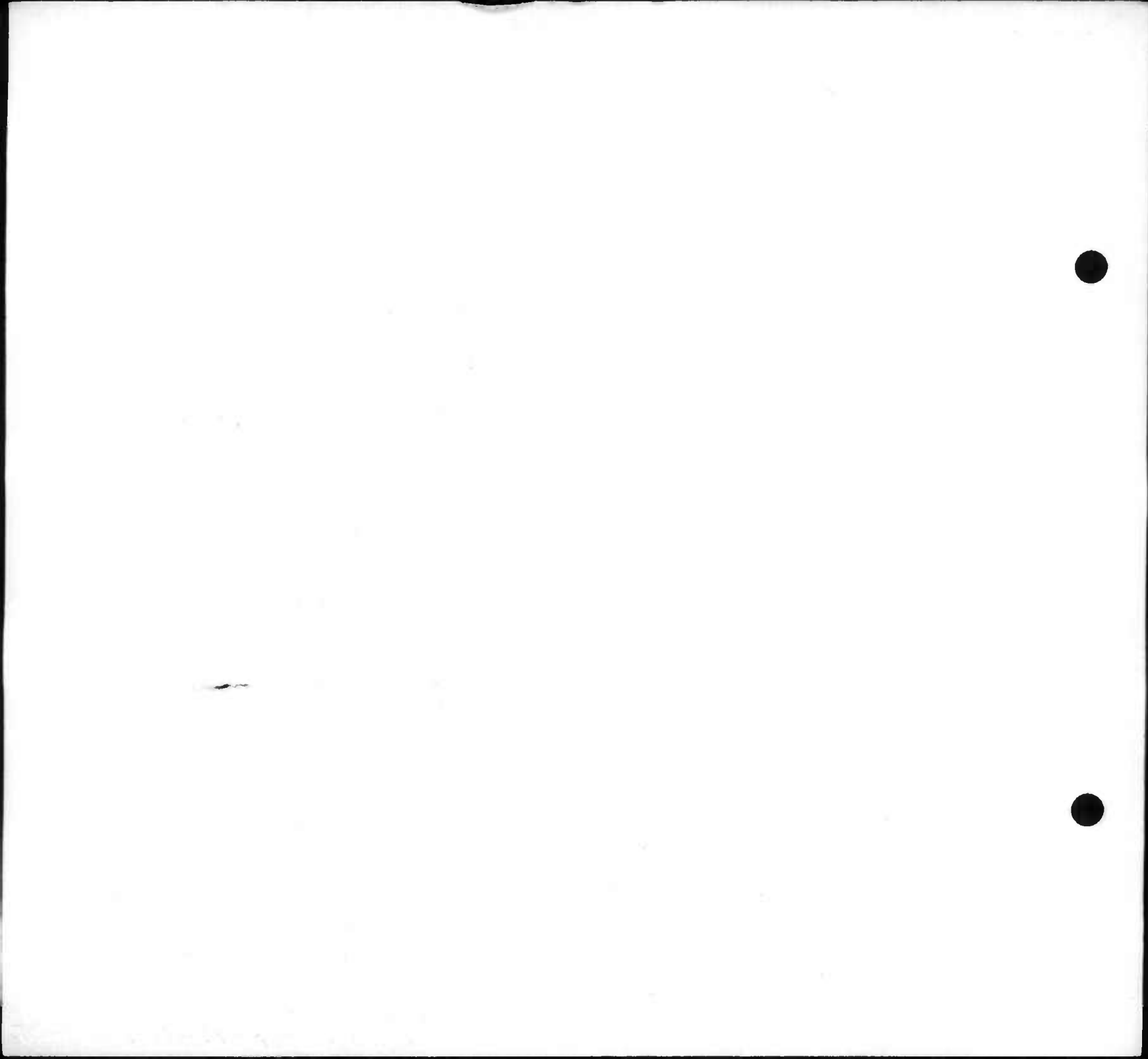
Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Delington Phillips 1727 N. Mount St.

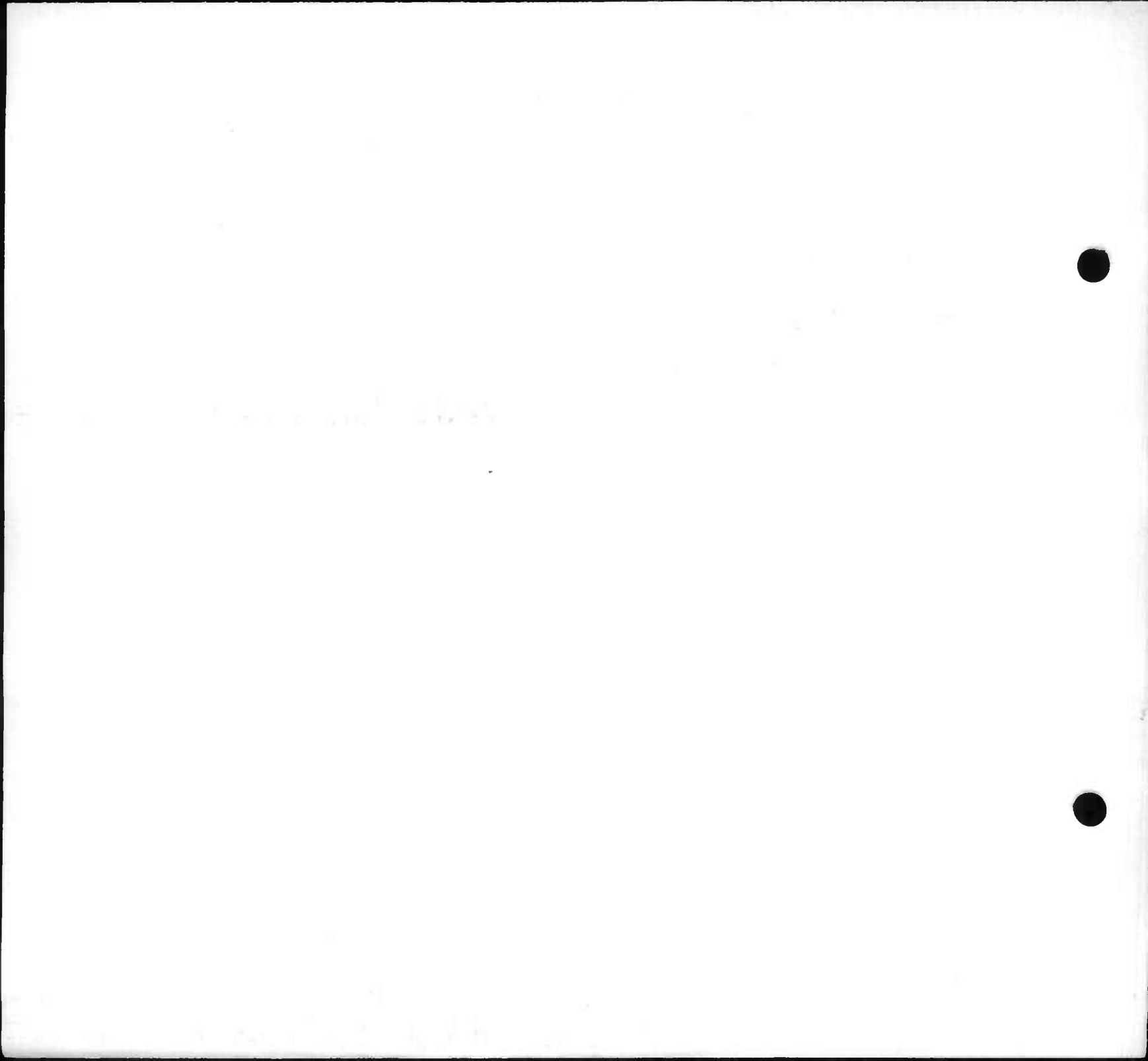
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



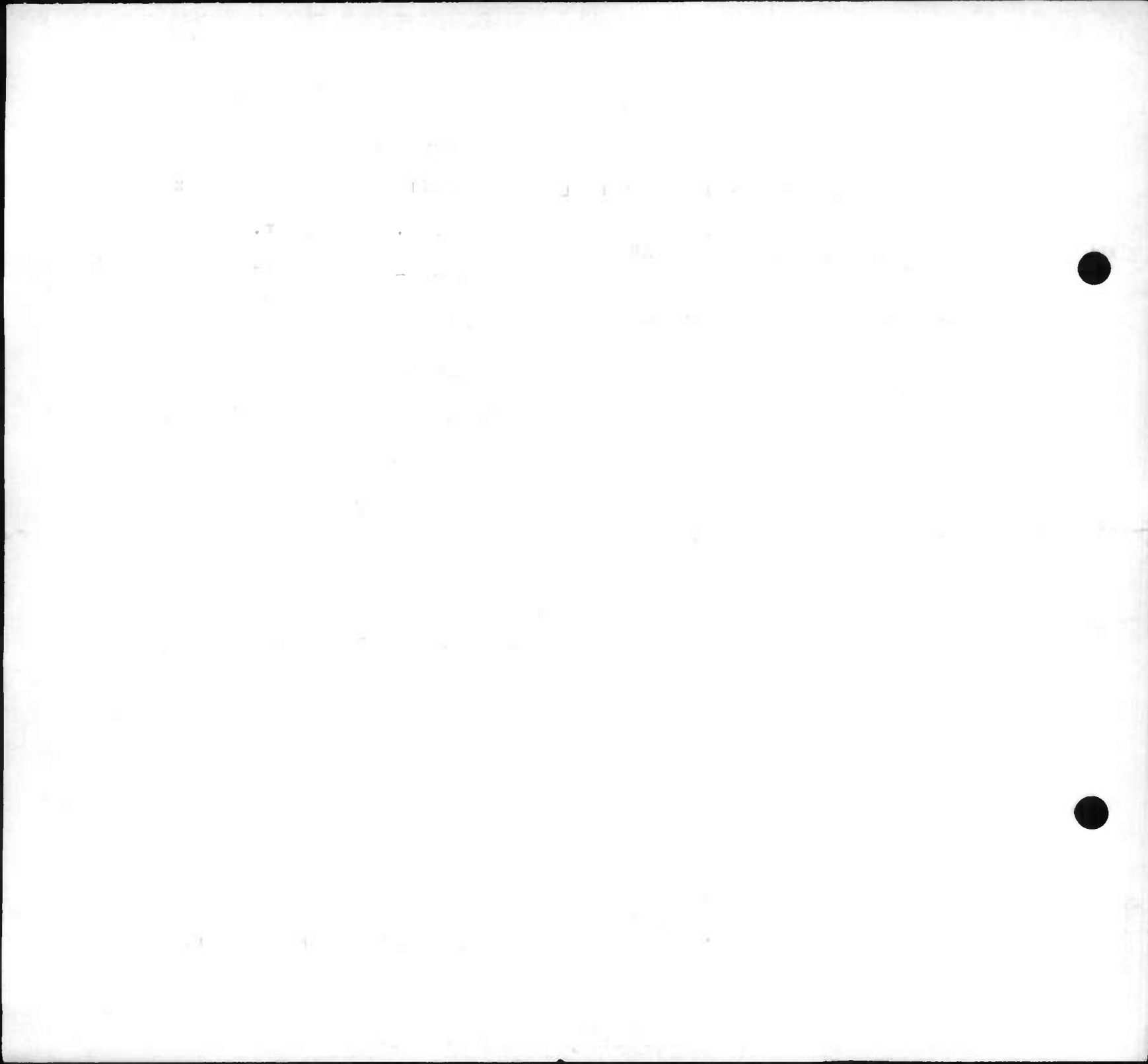
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6589		REG. NO. 70 6589	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Johnson, Aldora Mrs.</i>				2. DATE AND HOUR OF DEATH <i>6/25/70 6.45 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>34 Bon Secours Hosp.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2001</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>34 Bon Secours Hosp.</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>240 N. Payson St.</i>							
5. SEX <i>F</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/22/12</i>	9. AGE (In years last birthday) <i>57</i>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>TALLIE GRAHAM</i>			14. MOTHER'S MAIDEN NAME <i>Mollie Johnson</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes; no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Wade Johnson-240 N. Payson St</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <i>6/24/70</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Septic Shock</i> 20A. AUTOPSY? (Yes or No) <i>No</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6/24</i> 19 <i>70</i> to <i>6/25</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>6/25</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Mayuree Khongcharoensuk M.D.</i>				23B. DATE SIGNED <i>6/25/70.</i>			
23C. PHYSICIAN'S NAME (Type) <i>MAYUREE KHONGCHAROENSUK M.D.</i>				23D. ADDRESS <i>Bon Secours Hosp. Baltimore Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>6-26-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Silver Star Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Horry County, South Carolina</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1970</i>		25B. NAME OF REGISTRAR <i>W. E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Arlington S. Phillips</i>		ADDRESS <i>1727 N. Monroe St.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6590		REG. NO. 70 6590	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Fuller Branch</i>		2. DATE AND HOUR OF DEATH <i>6/28/70 8:15 p.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>704</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 THE JOHNS HOPKINS HOSPITAL</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>941 N. DALLAS ST.</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-23-15</i>	9. AGE (In years last birthday) <i>54</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Latimer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bugle Laundry</i>		11. BIRTHPLACE (State or foreign country) <i>VA.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>Annie Branch</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Alva Branch 1029 N. Caroline St</i>		ADDRESS	
18. <i>162.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>ca lung</i> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 10</i> 19 <i>70</i> to <i>6/28</i> 19 <i>70</i> and that (I) (we) last saw the deceased alive on <i>6/20</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>James L. Bolen</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>JAMES L. BOLEN</i>				23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/2/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>mt. Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>A.A. County Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUN 30 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Tabor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Joseph L. Locke, Jr.</i>		ADDRESS <i>1304 N. Central Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

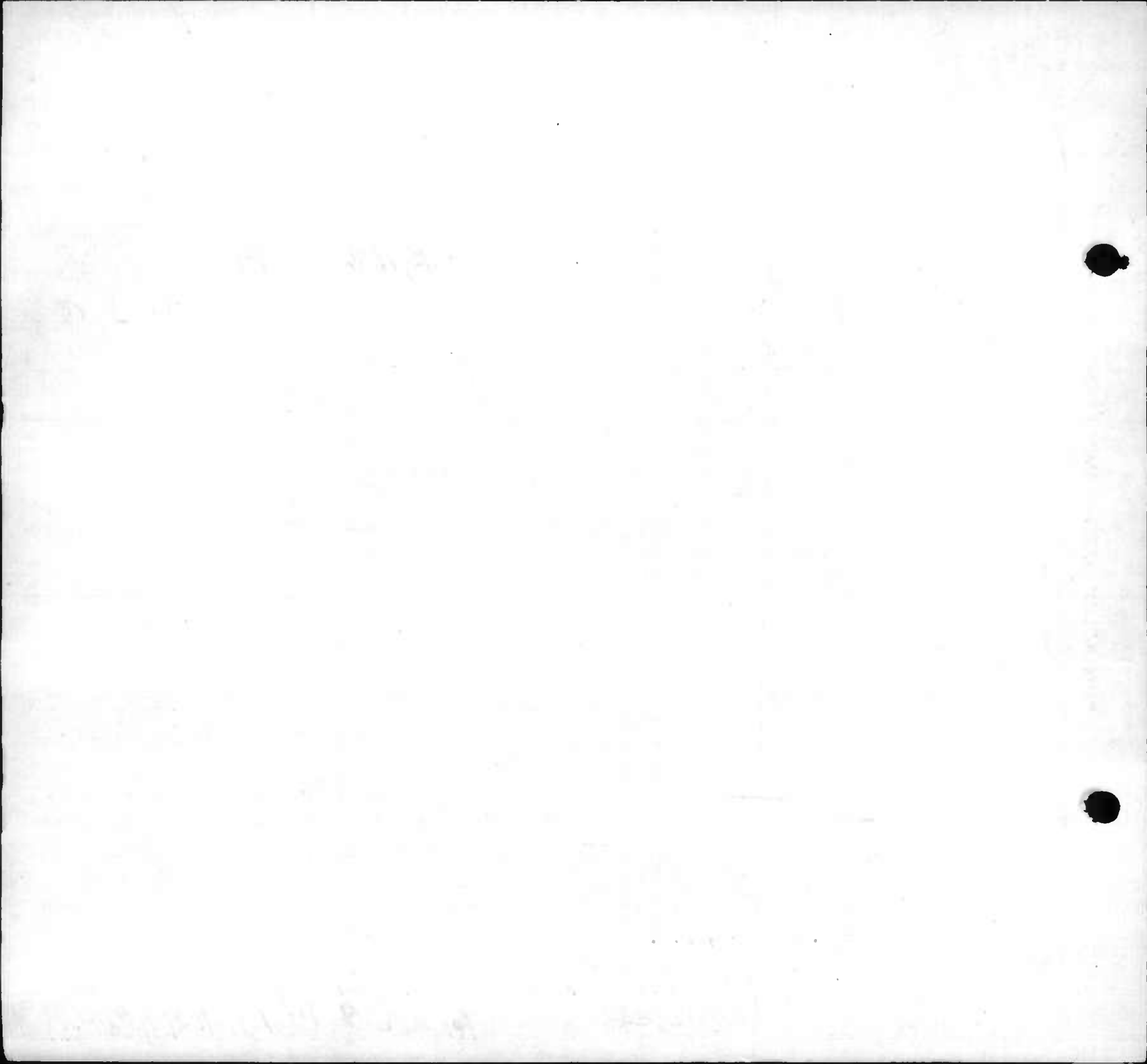
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6591	
B-300 70 6591				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Charles O. Boothe		2. DATE AND HOUR OF DEATH 6/27/70 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 805		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1901 N. Wolfe St.		
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1906	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Lee Boothe		14. MOTHER'S MAIDEN NAME Margaret Godwin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Grace L. Boothe ADDRESS 1901 N. Wolfe St.	
18. 41231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterolateral Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 18, 1970 to June 27, 1970 , that (I) (we) lost saw the deceased alive on June 10, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Roland T. Smoot, M.D.				23B. DATE SIGNED 6/29/70	
23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT, M.D.				23D. ADDRESS 2300 GARRISON BLVD, BALTO. 16, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/70		24C. NAME OF CEMETERY or CREMATORY Smithfield Va.	
24D. LOCATION (City, town, or county) (State) Smithfield Va.					
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Milton E. Elickson ADDRESS 1129 N. Caroline St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

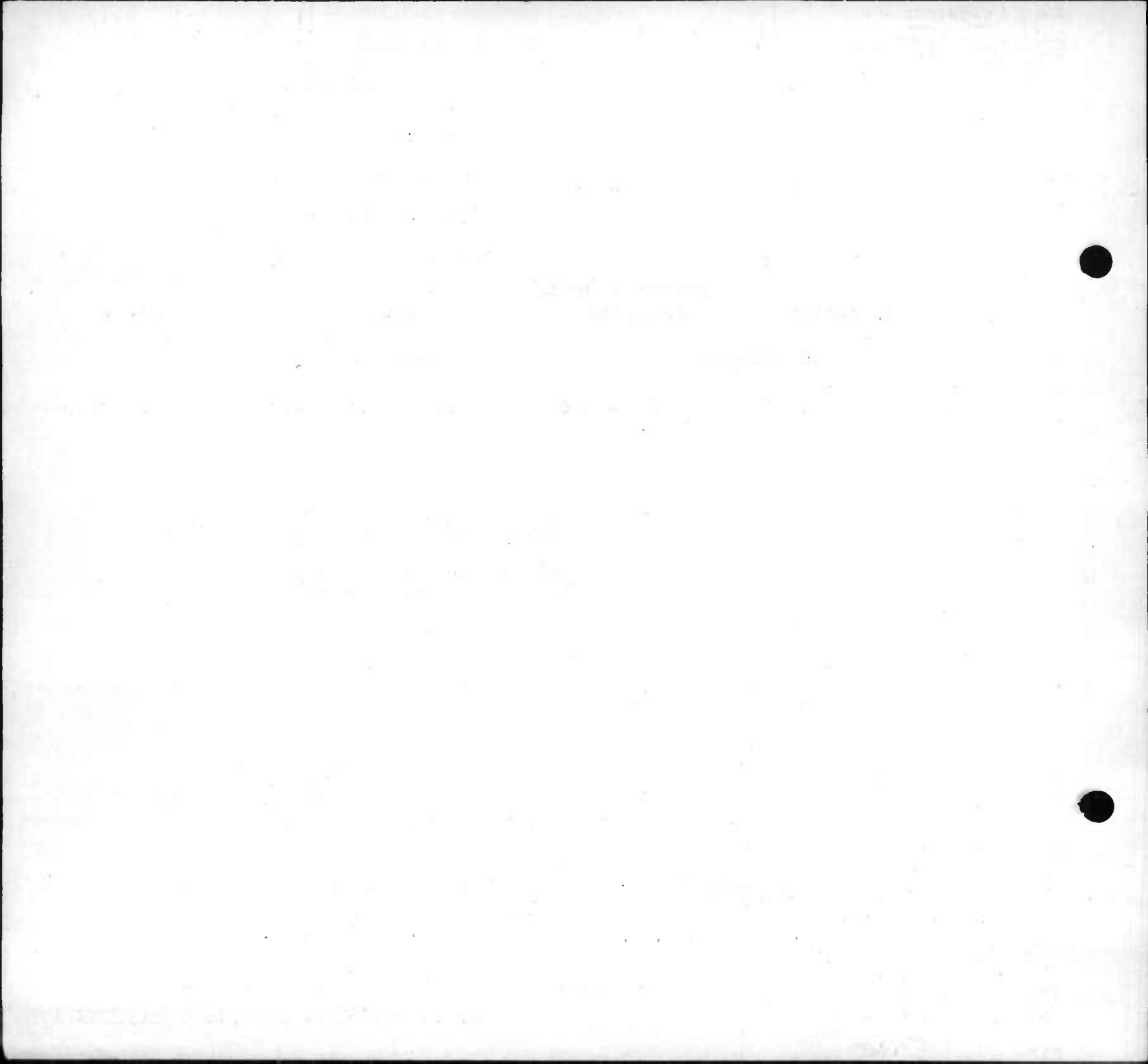
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 70 6592				
BIRTH NO. W-400 70 6592									
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Annie Wiley					2. DATE AND HOUR OF DEATH 6/29/70 4:47 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Belair House in the Pines					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 704 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1745 Oakland Ave.				
5. SEX Female		6. RACE Col		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow		8. DATE OF BIRTH Jan. 15, 1896		9. AGE (In years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Woodward S.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Simon Brown					14. MOTHER'S MAIDEN NAME Fannie Jackson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Eloise Wiley		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Carcinomatous DUE TO (B) Bronchogenic (squamous cell) Carcinoma DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH 7/yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					Late latent Lues Old Tuberculosis Old Peptic Ulcer			Yr	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5/20/70 to 6/29/70					that (I) (we) last saw the deceased alive on 6/22/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Albert B. Bradley					23B. DATE SIGNED 6/29/70			23C. PHYSICIAN'S NAME (Type) Albert B. Bradley, M.D.	
23D. ADDRESS 4900 Belair Road									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.			24D. LOCATION (City, town, or county) (State) Skeetport Md.		
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR ADDRESS Michael C. Clifton 1129 N. Calver St.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

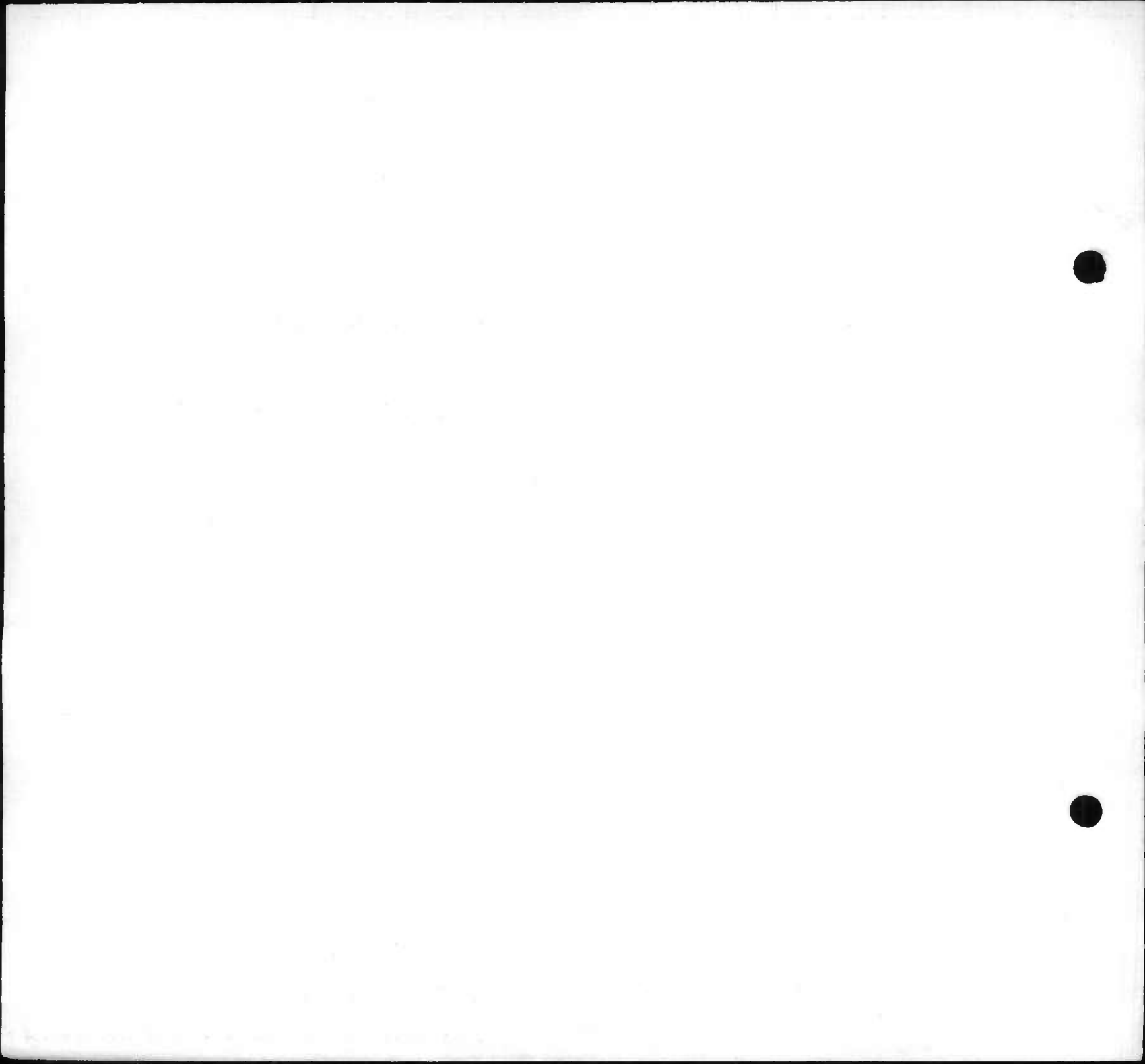
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6593	
B-432 70 6593 BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GUS (CONSTANTINE) BALDYGA			2. DATE AND HOUR OF DEATH June 29, 1970 10:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 601 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 133 N. Streeper Street		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/94	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician			10B. KIND OF BUSINESS OR INDUSTRY Copper & Brass Products		11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Luke Baldyga		
14. MOTHER'S MAIDEN NAME Unknown			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		
16. SOCIAL SECURITY NO. 216-03-0167			17. INFORMANT ADDRESS Mrs. Catherine Baldyga, 133 N. Streeper St		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Congestive heart failure Acute Respiratory Infection			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 12 1970 to June 28 1970 that (I) (we) last saw the deceased alive on June 27 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles C. Mac Minn M.D.				23B. DATE SIGNED June 30, 1970	
23C. PHYSICIAN'S NAME (Type) Charles C. Mac Minn, M. D.				23D. ADDRESS 2900 E. Baltimore St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/70		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970 25B. NAME OF REGISTRAR Robert E. Talley			
25C. FUNERAL DIRECTOR ADDRESS M.F. SADOWSKI & SONS, 1808 EASTERN AVE					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

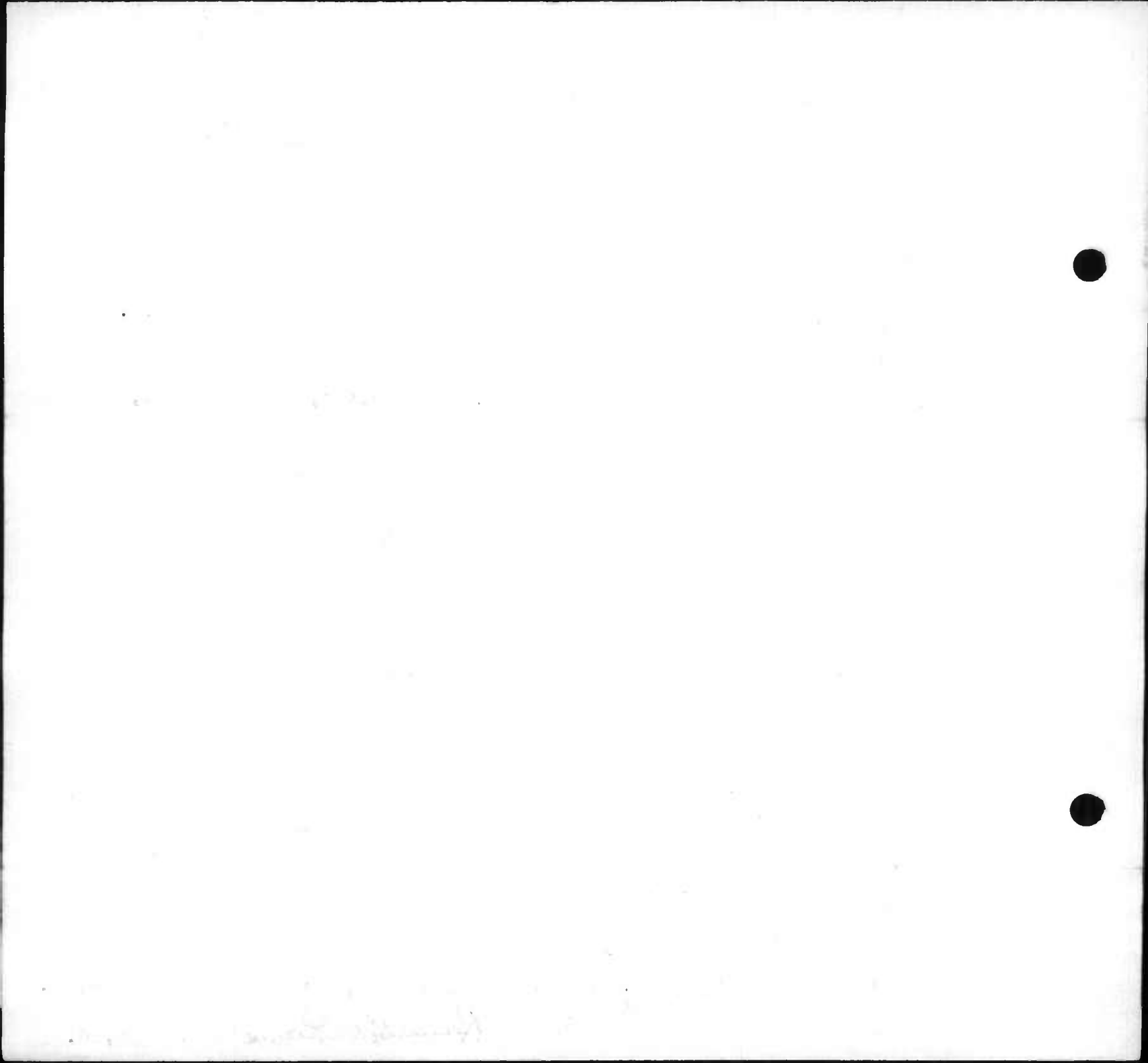
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6594</u>	
BIRTH NO. <u>70 6594</u>		1. NAME OF DECEASED (Type or Print) <u>Evelyn Thompson</u>			
2. DATE AND HOUR OF DEATH <u>6-26-70 12:06 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1205</u>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> <u>33 Balto. Md. 21205</u>			
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>12/18/66</u>		9. AGE (In years last birthday) <u>3½</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Mitchell Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Juanita Harvey</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hopkins Hospital</u>	
18. <u>74611</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Coronary Artery -</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Post op. Block - Hmilton -</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Transferring Great Vessels - ASD - Rudimentary</u> <u>(2) venous</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6-25-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>TGV ASD Rudimentary (2) V.</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-20-</u> 19 <u>70</u> to <u>6-26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6-26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>A. G. Reilly</u> M.D. DEGREE		23B. DATE SIGNED <u>6/26/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Antonio Gonzalez - Reilly Jr. M.D.</u> DEGREE	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-29-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>My Calvary Cem. A.C. Co.</u>	
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUN 30 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Rayner Sanders</u>		25D. ADDRESS <u>217 E. Preston St</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6595
BIRTH NO. 70 6595		
1. NAME OF DECEASED (Type or Print) SUSIE MARION HARRISON		2. DATE AND HOUR OF DEATH 6/26/70 1:30 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIV. HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY Dorchester C. CITY OR TOWN CAMBRIDGE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1408 RACE ST
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 6-18-14		9. AGE (in years last birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Henry BRIDGE		14. MOTHER'S MAIDEN NAME REGINA BAYNARD
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.
17. INFORMANT C. Lee Harrison, 1408 Race St., Cambridge		ADDRESS
18. 116.0 x 125.0.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CRYPTOCOCCAL MENINGITIS DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DIABETES MELLITUS DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. NONE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 9 YEARS
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). NONE		
19A. DATE OF OPERATION 6/25/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from 6/23 1970 to 6/26 1970 that (2) (we) last saw the deceased alive on 6/26 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.		
23A. SIGNATURE Jane E. Mahaffey M.D.		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) JANE E. MAHAFFEY, M.D.		23D. ADDRESS UNIVERSITY HOSPITAL
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE June 28, 70
24C. NAME OF CEMETERY or CREMATORY Dorchester Memorial Park, Cambridge		24D. LOCATION (City, town, or county) (State) Dorchester, Md.
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.
25C. FUNERAL DIRECTOR Samuel R. Johnson		ADDRESS Cambridge, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6596	
<div style="display: flex; justify-content: space-between;"> B-600 70 6596 CERTIFICATE OF DEATH </div>					
BIRTH NO. 1. NAME OF DECEASED (Type or Print) EDWARD HERMANUS BEYER		2. DATE AND HOUR OF DEATH June 27, 70 5:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Melchor Nursing Home		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 1102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Severn Apts., Cathedral St. 21201			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/13/1885	9. AGE (In years last birthday) 84	10. CITIZEN OF WHAT COUNTRY? U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Realtor		10B. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-24-7553		17. INFORMANT Sister-in-law ADDRESS 21201 Mrs. Leonard Griffiths, 101 W. Monument	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Carcinoma of Neck (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 8 1970 to June 27 1970 , that (I) (we) last saw the deceased alive on June 26 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Loy M. Zimmerman MD</i>		23B. DATE SIGNED June 29, 70		23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman MD	
23D. ADDRESS 3202 Harford Rd, Baltimore, Md		23E. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av. (1)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/70		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. JUN 30 1970			
24F. NAME OF REGISTRAR Robert E. Fisher, Jr.		24G. ADDRESS 108 W. North Av. (1)			

701 Cathedral St.
called nursing home.

H-620

70

6597

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6597

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ERIC HARRIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour June 24, 1970 5:00 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8.33	
9. DATE OF BIRTH 3/24/61		10. AGE (in years last birthday) 9	
11. BIRTHPLACE (State or foreign country) Okinawa		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jack Harris		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	
15. MOTHER'S MAIDEN NAME Vera		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs Joyce Guess, (Social Worker)	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E910.9		CAUSE OF DEATH (A) IMMEDIATE CAUSE Drowning DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 6/30/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) pond	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rear of 3300 E. Madison St. (Baltimore Brick Co.)		22D. TIME OF INJURY (APPROX.) Month Day Year Hour ? ? ? ?	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Apparently drowned	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE: Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type): Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED June 25, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/70	
24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore M	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W North Ave	

1933

QUALITY CONTROL

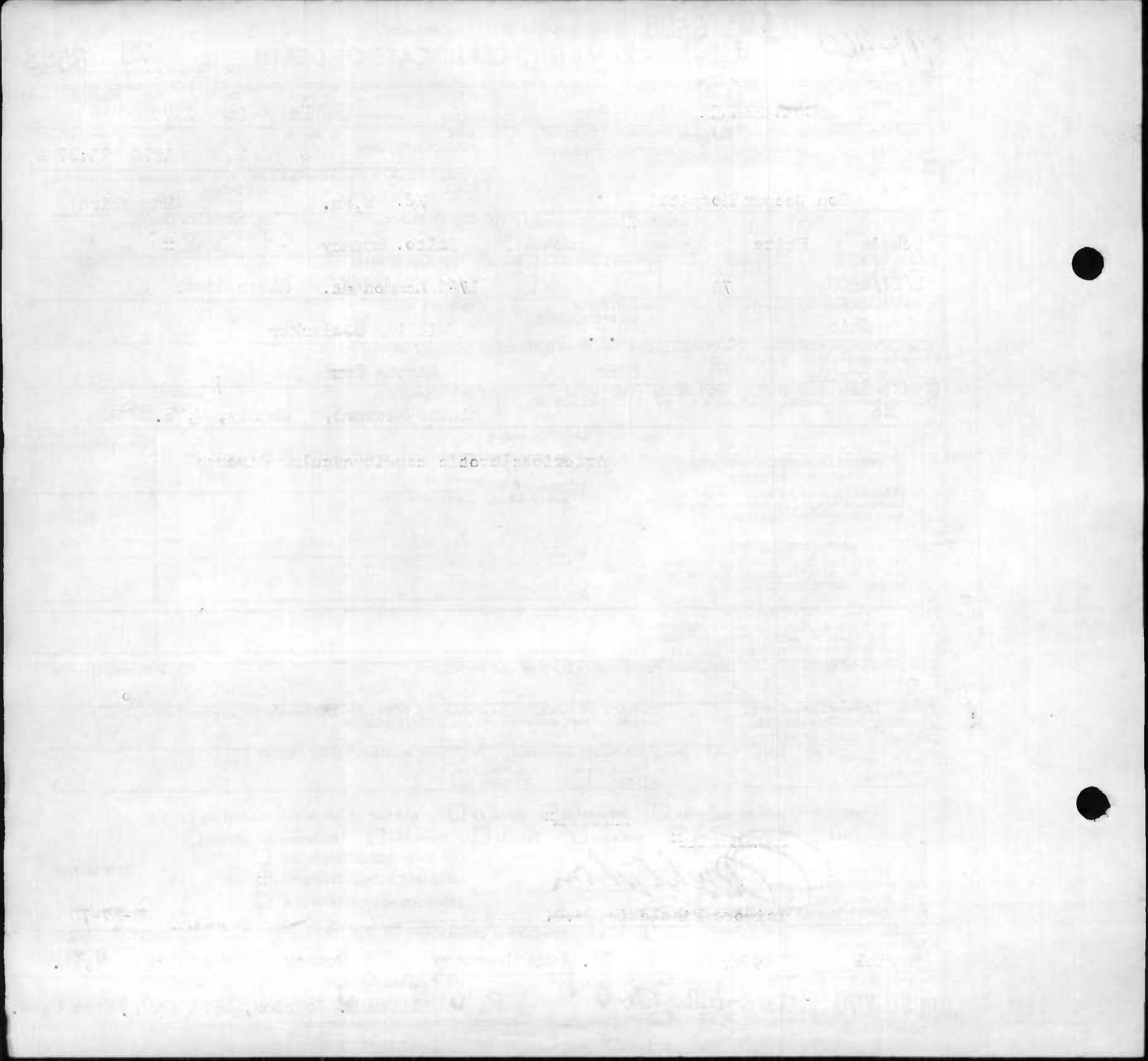
QUALITY CONTROL

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

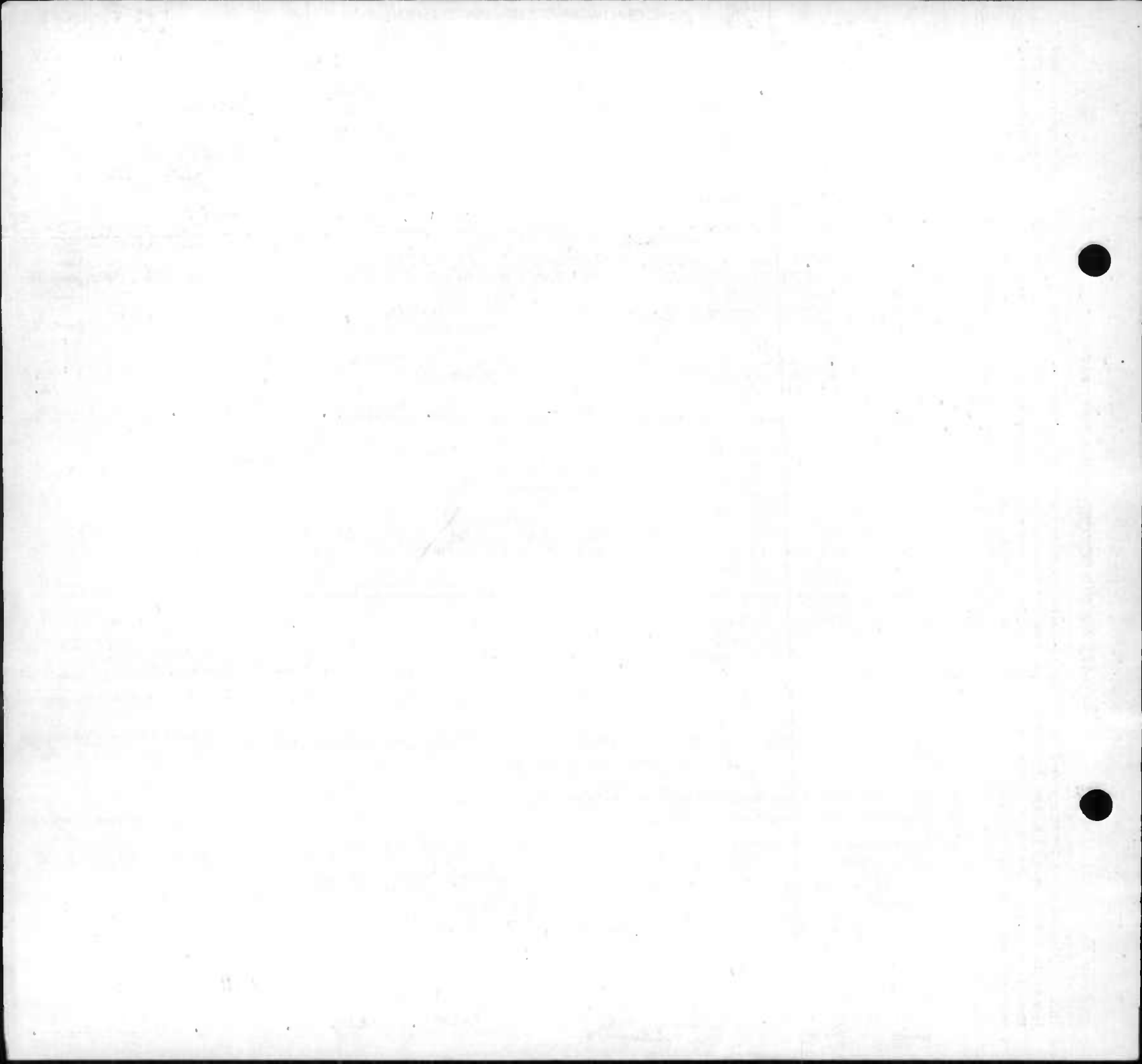
1. NAME OF DECEASED (Type or Print) CORA MILLAR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> JUNE 26 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secour Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 26 1970 11:37 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Ma. W, Va. B. COUNTY Hampshire	
9. DATE OF BIRTH 2/27/1900		10. AGE (in years last birthday) 70	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home	
13. FATHER'S NAME William Haslacker		15. MOTHER'S MAIDEN NAME Martha Cox	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Elaine Wickman, Romney, W, Va.		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-27-70 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/70	
24C. NAME OF CEMETERY or CREMATORY St. Luke Cemetery		24D. LOCATION (City, town, or county) (State) Romney Hampshire W, Va.	
25A. DATE REC'D BY HEALTH DEPT. JUN 30 1970		25B. NAME OF REGISTRAR Robert E. Fabe, M.D.	
25C. FUNERAL DIRECTOR William B. Johnson, 8521 Loch Raven Blvd.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-460</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6599</u>			
1. NAME OF DECEASED (Type or Print) <u>John S. Wall</u>				2. DATE AND HOUR OF DEATH <u>June 27, 1970</u>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE <u>Maryland</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital</u>				B. COUNTY <u>702</u>				C. CITY OR TOWN <u>Baltimore</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <u>2612 E. Jefferson Street</u>			
5. SEX <u>M.</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/96</u>	9. AGE (In years last birthday) <u>74</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Local #1</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Edward R. Wall</u>				14. MOTHER'S MAIDEN NAME <u>Cornelia Machen</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-09-0539</u>				17. INFORMANT <u>Mrs. Irene M. Wall</u>			
18. <u>410.91-185X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ant-rel cc disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma prostate</u>											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>											
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>no</u>				20A. AUTOPSY? (Yes or No) <u>no</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>no</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Maurice Feldman</u>								Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>MAURICE FELDMAN JR</u>								23D. ADDRESS <u>6610 CROSS COUNTRY BLVD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>7/1/70</u>				24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>			
24D. LOCATION <u>Baltimore, Maryland</u>				24E. LOCATION (City, town, or county) (State)							
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 30 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>				25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u>			
ADDRESS <u>3000 E. Baltimore St.</u>											



FUNERAL DIRECTOR: IMPORTANT

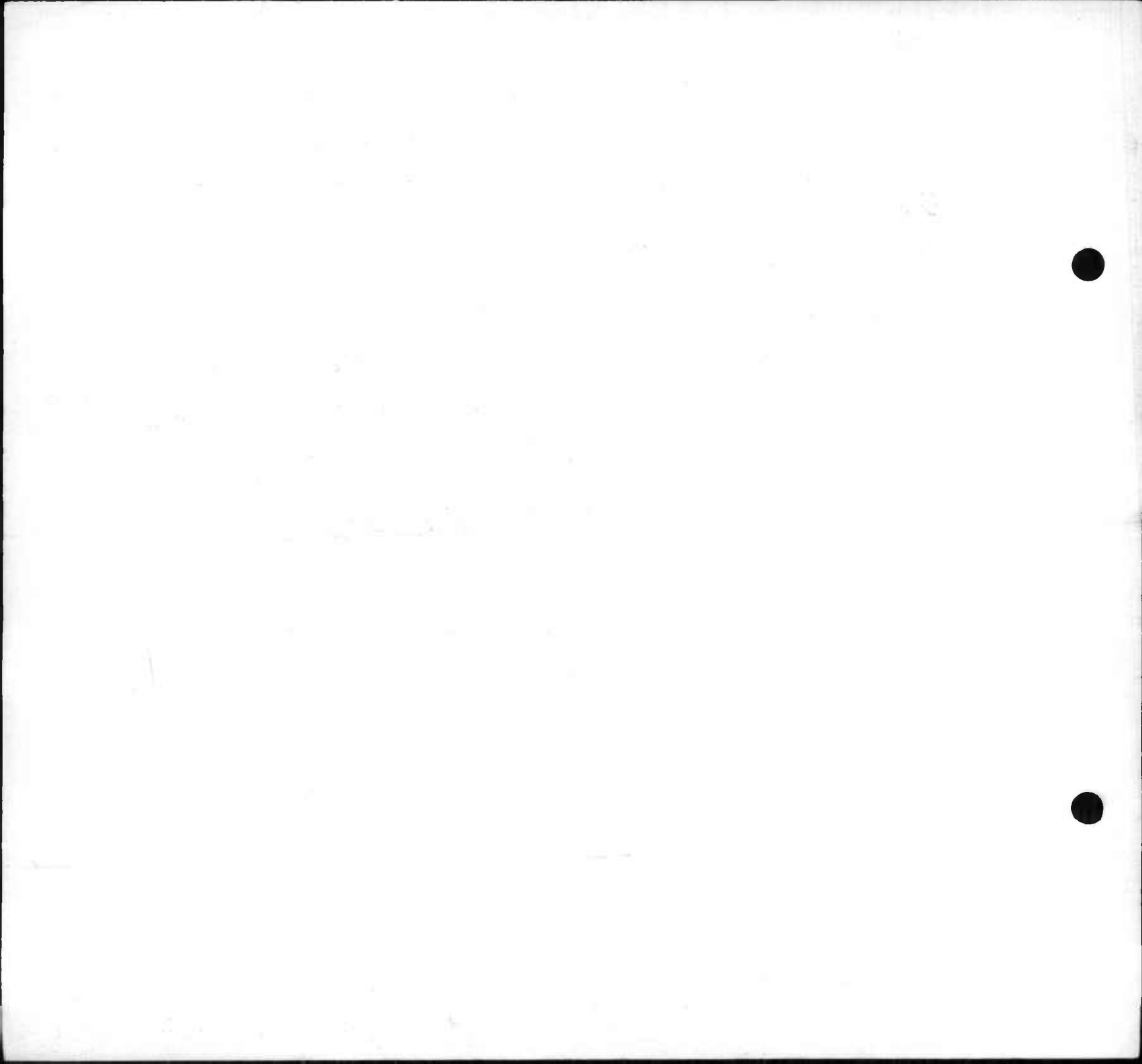
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-553		70 6600		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6600		
1. NAME OF DECEASED (Type or Print) COMMANDER MARIE					2. DATE AND HOUR OF DEATH June 27, 1970 3:20 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harbor View Nursing Home 1213 Light St.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1203 Hagerway #21224					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/24/196	9. AGE 74 (years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk City Police Dept.		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk City Police Dept.					10B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN NEMEC					14. MOTHER'S MAIDEN NAME MARY ROKSKY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 217-16-6360		17. INFORMANT MRS EVELYN KIEL		ADDRESS 7538 LAWRENCE RD. BALTO. 21222, MD.	
18. 483X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Grandeur pneumonia					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Grandeur pneumonia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO, OR AS A CONSEQUENCE OF: (C) 					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Smoking / diabetes										2 min
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7 May 1970 to 27 Jun 1970 that (I) (we) last saw the deceased alive on 27 Jun 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE J. Holla MD					23B. DATE SIGNED 27 Jun 70					
23C. PHYSICIAN'S NAME (Type) J. Holla M.D.					23D. ADDRESS 2714 E. Fayette 21221					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 6-30-70		24C. NAME of CEMETERY or CREMATORY HOLY CROSS CEMETERY		24D. LOCATION (City, town, or county) (State) 6020 RITCHIE HIGHWAY, A.A. CO., MD.				
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Charles J. Geiler		ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6601</u>
BIRTH NO. <u>L-236</u> <u>70 6601</u>		1. NAME OF DECEASED (Type or Print) <u>ETHEL M. LEISTER</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u>		2. DATE AND HOUR OF DEATH <u>6-26-70</u> <u>9:20 A.M.</u>		
5. SEX <u>female</u>		6. RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>		10. KIND OF BUSINESS OR INDUSTRY <u>—</u>		
13. FATHER'S NAME <u>J. GRANT DELL</u>		14. MOTHER'S MAIDEN NAME <u>? IDA ALLGIRE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>29-36 1394</u>		17. INFORMANT <u>MR. IRA L. LEISTER, WESTMINSTER, RT#4, MD.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Sudden Acute Coronary Endocarditis?</u> (A) IMMEDIATE CAUSE <u>PULMONARY EMBOLISM</u> DUE TO, OR AS A CONSEQUENCE OF: <u>PERIPHERAL VASCULAR DISEASE?</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>PERIPHERAL HEART DISEASE</u> (C) <u>PERIPHERAL HEART DISEASE</u> <u>PERIPHERAL HEART DISEASE</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PERIPHERAL HEART DISEASE</u>				
19A. DATE OF OPERATION <u>6-26-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PERIPHERAL HEART DISEASE</u>		20A. AUTOPSY (Yes or No) <u>YES</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? (If in Baltimore City, give exact location)
22. I certify that (I) (this hospital) attended the deceased from <u>6-13</u> 19 <u>70</u> to <u>6-26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6-26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Gregorio Clearfiori MD</u>		23B. DATE SIGNED <u>6-26-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Gregorio Clearfiori MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/29/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>LEISTERS CEMETERY</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>J. E. Miller, Jr. Westminster, Md.</u>
24D. LOCATION (City, town, or county) (State) <u>WESTMINSTER, RT#4, MD.</u>		25D. ADDRESS <u>—</u>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6602

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EIMER J. MARSHALL				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 6 25 1970 9:25 P. M.			
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10-31-24				10. AGE (In years last birthday) 45		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James T. Marshall			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator				15. MOTHER'S MAIDEN NAME Lillie Herring			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II				17. SOCIAL SECURITY NO. 227-20-5394			
18. INFORMANT Wife: Mrs. Pauline C. Marshall				19. ADDRESS 7426 Holabird Ave. Dundalk, Md. 21222			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fracture dislocation of cervical spine with compression of spinal cord				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home			
22D. TIME OF INJURY (APPROX.) 6-25-70 8:13p				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 7426 Holabird Ave. 5300				22F. HOW DID INJURY OCCUR? Fell down steps.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, MD.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 6-26-70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-70		24C. NAME of CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE AMENDED - 7/9/70

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6603	
BIRTH NO. L-526 70 6603		1. NAME OF DECEASED Ronald J. Lengrand (Type or Print) RONALD LENGRAND	
2. DATE AND HOUR OF DEATH 6-26-70 7:40 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CHURCH HOME HOSPITAL	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		5. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2519 Lodge Forest Drive		6. SEX M 7. RACE W	
8. DATE OF BIRTH 2-7-53		9. AGE (in years last birthday) 17	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME MAURICE J. LENGRAND	
14. MOTHER'S MAIDEN NAME GALE R. ROHLER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) No	
16. SOCIAL SECURITY NO. 219-62-2862		17. INFORMANT Mother: 2519 Lodge Forest Dr. Balto. Md. 21219	
18. 155.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH HEPATOMA (HEPATIC CELL CARCINOMA) CARDIORESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: With Generalized Metastasis (B) GENERAL DETERIORATED CONDITION DUE TO, OR AS A CONSEQUENCE OF: (C) INFOSARCOMA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-19-70 to 6-26-70 that (I) (we) last saw the deceased alive on 6-26-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Carlos A. Lea Plaza		23B. DATE SIGNED 6-26-70	
23C. PHYSICIAN'S NAME (Type) CARLOS A. LEA PLAZA		23D. ADDRESS CHURCH HOME HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-70	
24C. NAME OF CEMETERY OR CREMATORY Mount Olivet		24D. LOCATION (City, town, or county) (State) New Cumberland, Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Bailey	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	

7/9/70 - Letter from Church Home Hospital. J.C.

CERTIFICATE OF DEATH

REG. NO.

70 6604

BIRTH NO.

1. NAME OF DECEASED (Stasys Vysniausks)

Vishniewski, Stanley M.

2. DATE AND HOUR OF DEATH

June 27, 1970 9:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN

Dundalk

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

2937 Liberty Parkway 21222

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

1-15-85

9. AGE (In years; last birthday)

85

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Self-employed-Clothing

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Not Known

14. MOTHER'S MAIDEN NAME

Not Known

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

099-10-8792

17. INFORMANT

4940 Eastern Avenue

BCH: Records Baltimore, Maryland 21224

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumococcal Pneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

18 hours

(B)

DUE TO, OR AS A CONSEQUENCE OF:

COPD, ASCVD with Atrial Fib

many years

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A)

Azotemia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 6/27 19 70 to 6/27 19 70
 that (1) (we) lost saw the deceased alive on 6/27 19 70 and that in (my) (our) opinion death occurred on the date
 and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Edward J. Lee

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

6/27/70

23C. PHYSICIAN'S NAME (Type)

Edward J. Lee

DEGREE

23D. ADDRESS

DEGREE

Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-30-1970

24C. NAME of CEMETERY or CREMATORY

Old St. John's

24D. LOCATION (City, town, or county)

Long Island, N.Y. Queens Co.

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

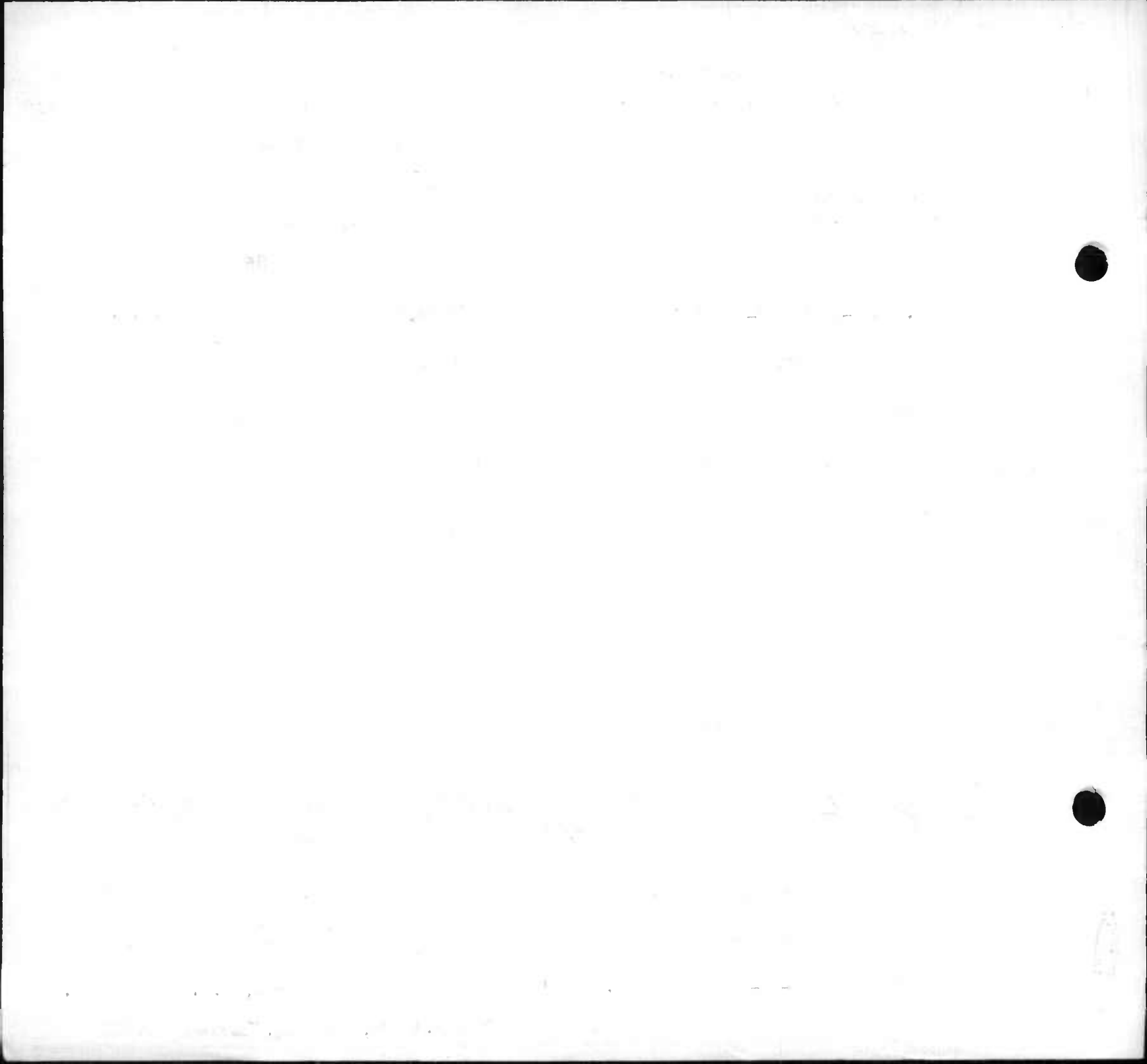
John J. Duda

ADDRESS

Dundalk, Maryland 21222

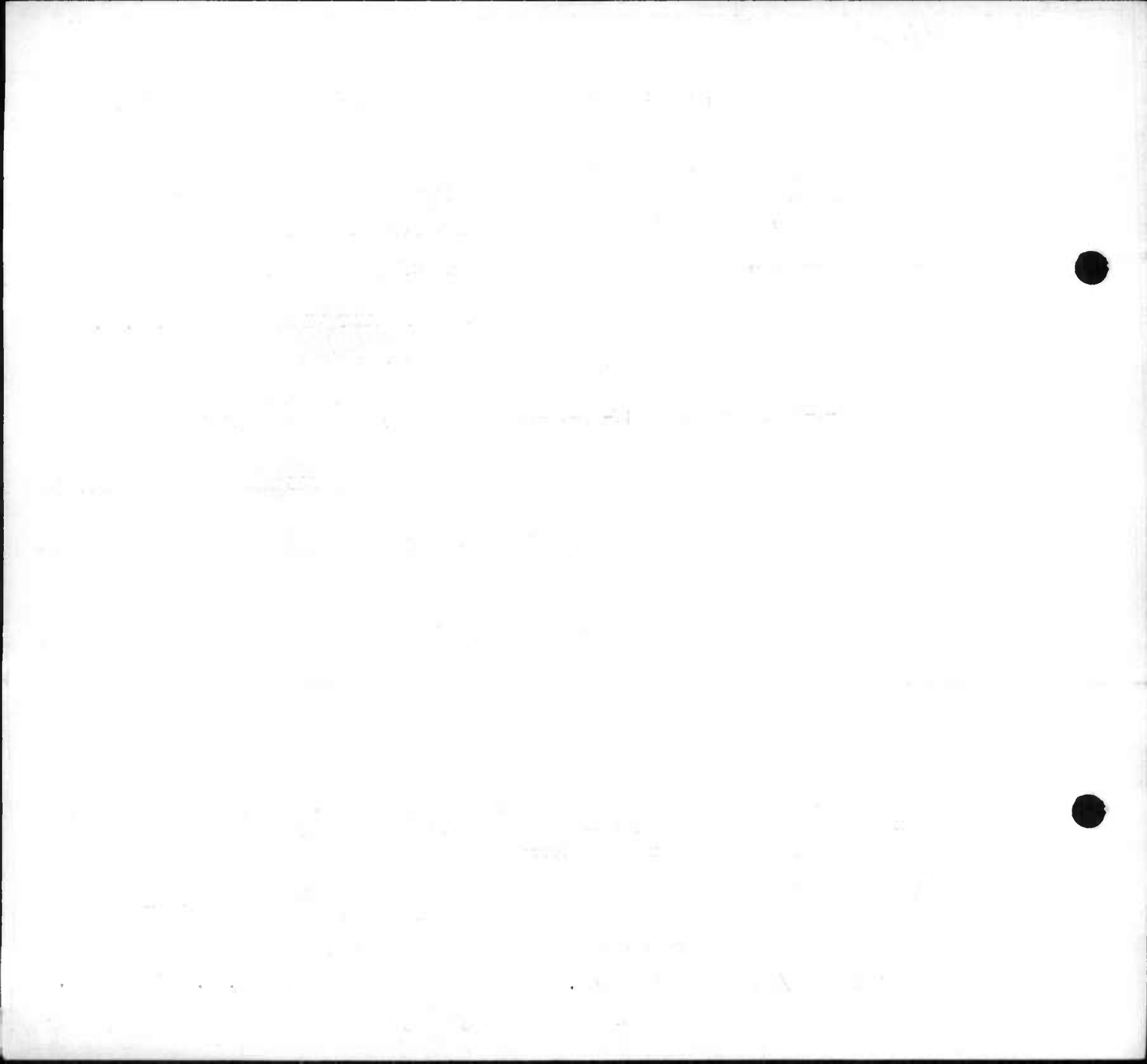
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

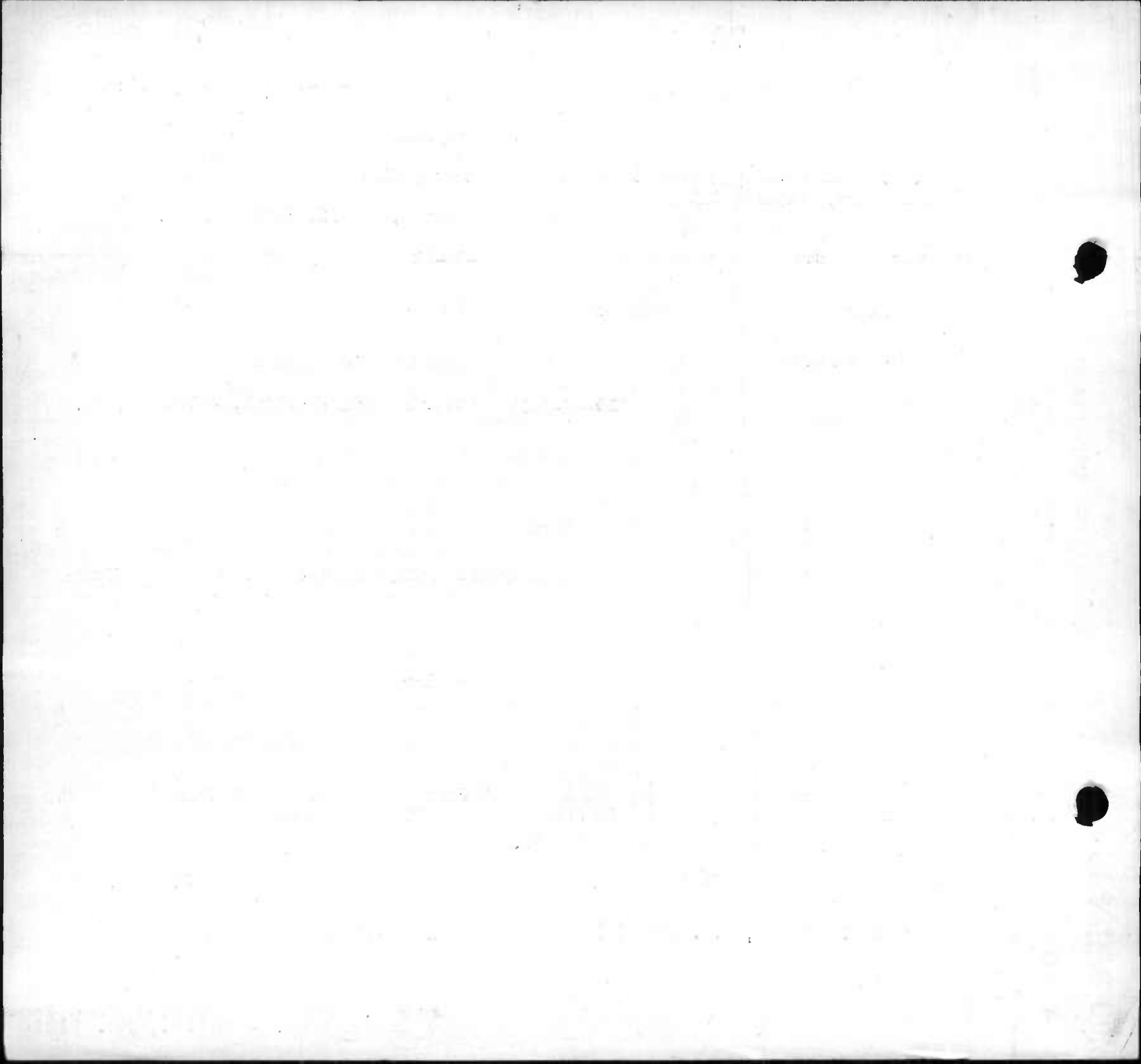
<p>BIRTH NO. M-630 70 6605</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 70 6605</p>															
<p>1. NAME OF DECEASED (Type or Print) MOOREHEAD, Robert William</p>				<p>2. DATE AND HOUR OF DEATH 25 JUNE 1970 6:25 P M.</p>											
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BOULEVARD BALTIMORE, MARYLAND 21218</p>				<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2505 2600 BUNGALOW ROAD</p>											
<p>5. SEX MALE</p>		<p>6. RACE CAUCASIAN</p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 9-30-15</p>		<p>9. AGE (In years last birthday) 56</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER</p>		<p>11. BIRTHPLACE (State or foreign country) PIEDMONT WEST VIRGINIA</p>		<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>	
<p>13. FATHER'S NAME ROBERT MOOREHEAD</p>				<p>14. MOTHER'S MAIDEN NAME MAUDE KIGHT</p>											
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 5-7-42 TO 5-20-46</p>				<p>16. SOCIAL SECURITY NO. 217-05-01-16</p>		<p>17. INFORMANT VA HOSPITAL RECORDS ADDRESS BALTIMORE, MARYLAND 21218</p>									
<p>18. CAUSE OF DEATH</p>															
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>						<p>(A) IMMEDIATE CAUSE CEREBRAL METASTASIS DUE TO, OR AS A CONSEQUENCE OF: (B) CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p>									
<p>II</p>															
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PULMONARY TUBERCULOSIS</p>															
<p>19A. DATE OF OPERATION 0</p>				<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>				<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>				<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>				<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>							
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>				<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>				<p>21F. HOW DID INJURY OCCUR?</p>							
<p>22. I certify that (A) (this hospital) attended the deceased from 24 JANUARY 19 70 to 25 JUNE 19 70 that (X) (we) last saw the deceased alive on 25 JUNE 19 70 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (B) (We) (did) (did not) view the body after death.</p>															
<p>23A. SIGNATURE [Signature]</p>								<p>23B. DATE SIGNED 6-26-70</p>							
<p>23C. PHYSICIAN'S NAME (Type) SAM A BRAHIM, M D</p>								<p>23D. ADDRESS 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218</p>							
<p>24A. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>				<p>24B. DATE 6/29/70</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Philos Cem.</p>		<p>24D. LOCATION (City, town, or county) (State) Westernport, Md. Allegany Md.</p>							
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970</p>				<p>25B. NAME OF REGISTRAR Robert E. Taylor, R.D.</p>				<p>25C. FUNERAL DIRECTOR [Signature] ADDRESS 3900 Loch Raven Rd. Westernport, Md.</p>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
70 6606 CERTIFICATE OF DEATH											
X REG. NO. 70 6606											
BIRTH NO. <u>M-620</u>											
1. NAME OF DECEASED (Type or Print) <u>George Weldon Moores</u>						2. DATE AND HOUR OF DEATH <u>6-28-70</u> <u>12:15</u> P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>U. S. PublicHealth Service Hospital</u> <u>Baltimore, Maryland 21211</u>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>H.A.C.O.</u> C. CITY OR TOWN <u>Crownsville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Route 1, Box 355 Round Bay Rd.</u>					
5. SEX <u>Male</u>	6. RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-29-12</u>		9. AGE (In years last birthday) <u>57</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oiler</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>seafarer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Moores</u>						14. MOTHER'S MAIDEN NAME <u>Katherine Ziedenhein</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-14-3137</u>		17. INFORMANT ADDRESS <u>Records USPHS Hospital, Baltimore, Md.</u>					
18. <u>7-5-3-11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Pneumonia</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Uremia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Polycystic kidney disease</u> (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Months</u> <u>Years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <u>XII</u> (this hospital) attended the deceased from <u>7 June</u> 19 <u>70</u> to <u>28 June</u> 19 <u>70</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>28 June</u> 19 <u>70</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) <u>(not)</u> view the body after death.											
23A. SIGNATURE <u>Gary E. Feldman, M.D.</u> DEGREE								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>June 29, 1970</u>	
23C. PHYSICIAN'S NAME (Print) <u>GARY E. FELDMAN, S.A. Surg (R)</u> DEGREE								23D. ADDRESS <u>USPHS Hospital, Baltimore, Maryland</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Feldman, M.D.</u>				25C. FUNERAL DIRECTOR'S ADDRESS <u>Robert C. Altenburg Funeral Home Inc.</u> <u>6009 Harford Rd. - Balto., Md. 21214</u>			

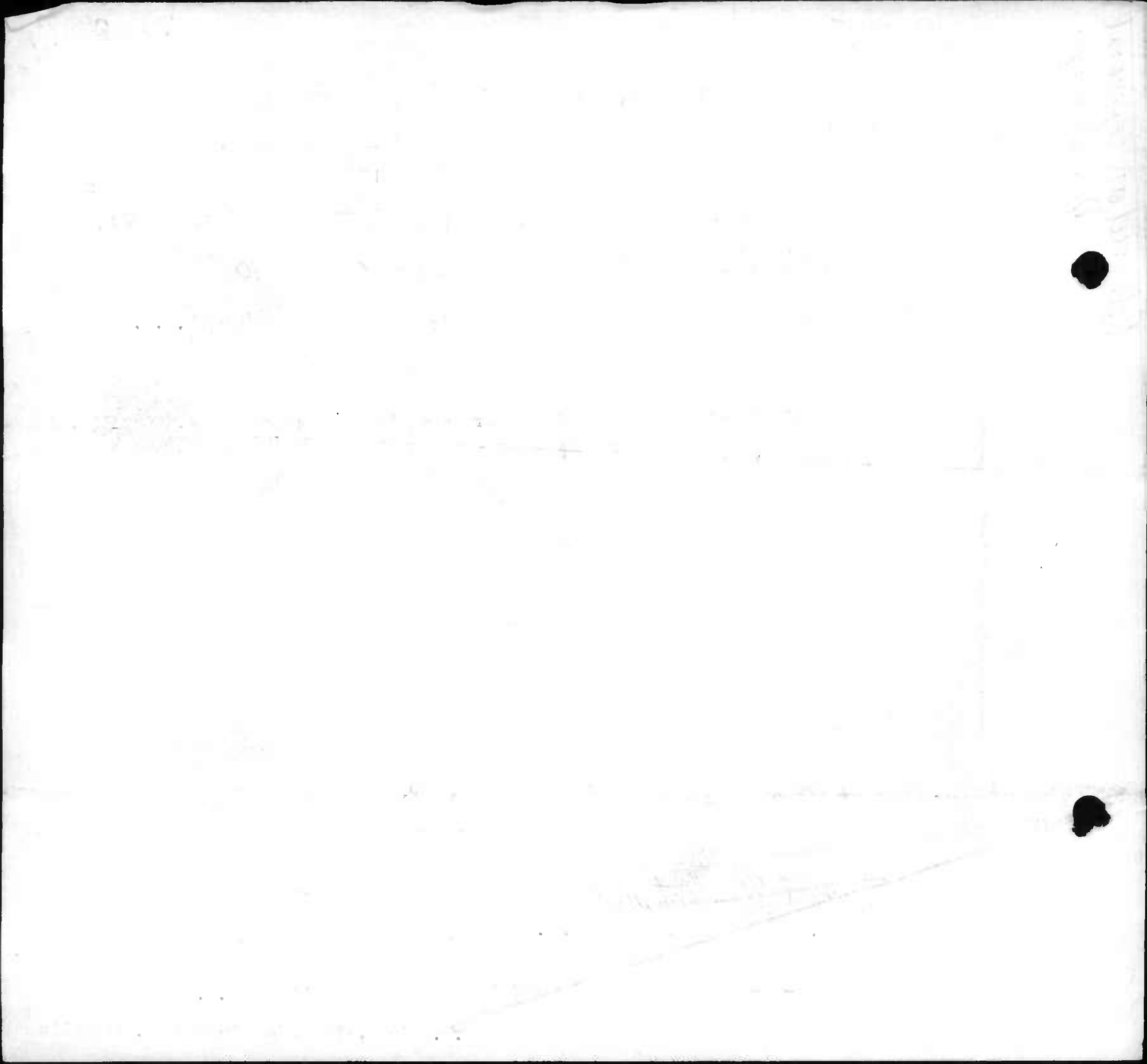


Released on Approval
Dr. DeMayo

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

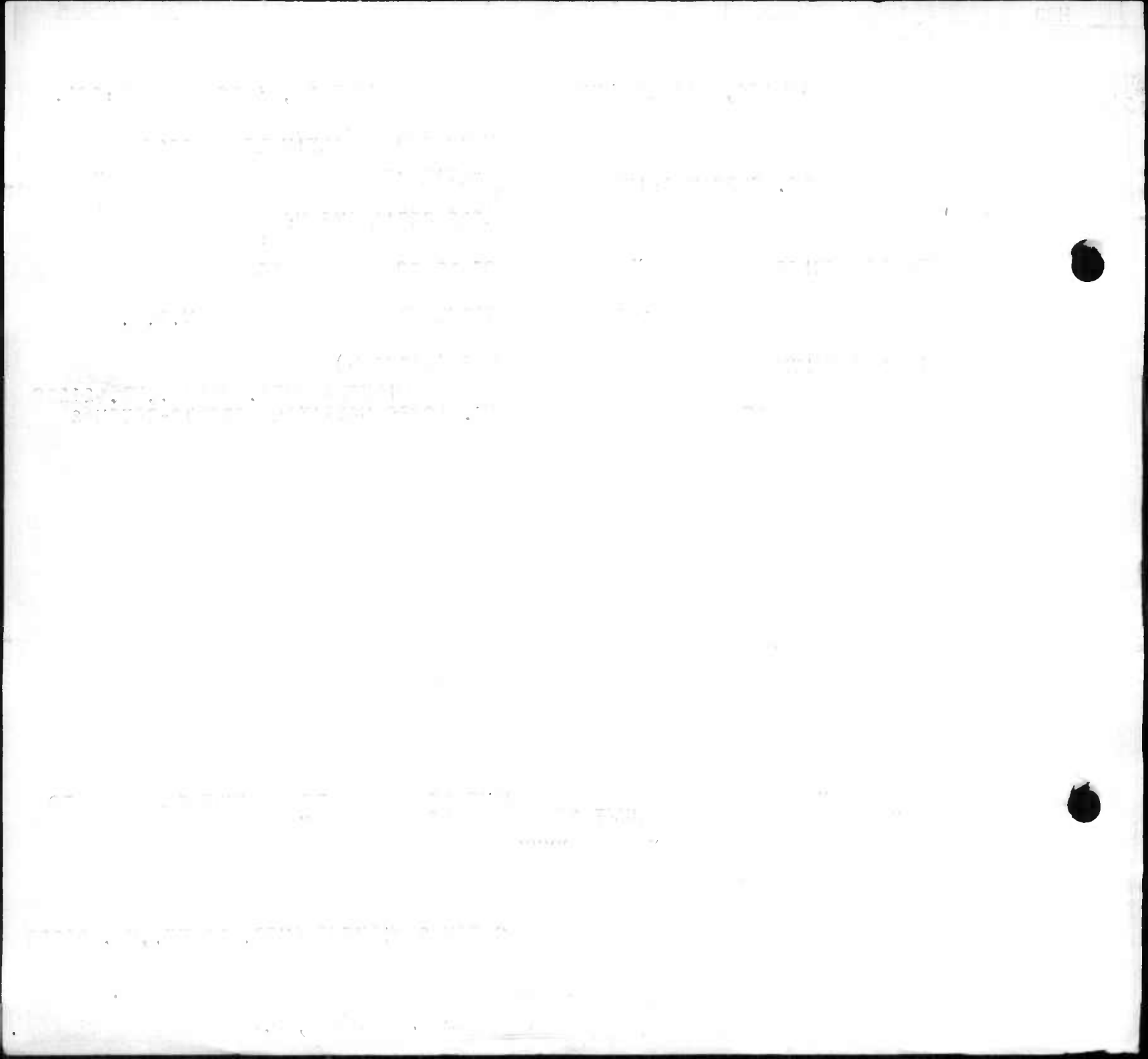
W-325		70 6607		BALTIMORE CITY HEALTH DEPARTMENT		X		70 6607	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.			
		Alice Nora Watson		6/24/70 12 ²⁵ P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland - Anne Arundel 5210					
33 Johns Hopkins Hospital - Balt., Md.				C. CITY OR TOWN ANNAPOLIS				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 62 Cathedral St. 21401					
5. SEX F		6. RACE No N-White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-28-99		9. AGE (In years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HAYES JOHNSON				14. MOTHER'S MAIDEN NAME ALICE ANDERSON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ***** 382-20-8212		17. INFORMANT Dr Faye Allen 62 Cathedral St. Annapolis, Md				ADDRESS	
18. 395.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac arrest, Heart Block during Catheterization (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aortic Stenosis, calcific ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertension									
19A. DATE OF OPERATION 7/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/17 19 70 to 6/24 19 70 that (I) (we) last saw the deceased alive on 6/24 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE G. Michael Vincent, M.D.				23B. DATE SIGNED 6/24/70					
23C. PHYSICIAN'S NAME (Type) G. MICHAEL VINCENT, M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-27-1970		24C. NAME OF CEMETERY or CREMATORY Pine Lawn Memorial Pk		24D. LOCATION (City, town, or county) (State) Annapolis A.A. Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Gable, M.D.		25C. FUNERAL DIRECTOR C.E. Hicks, 141 30 Washington St, Annapolis		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

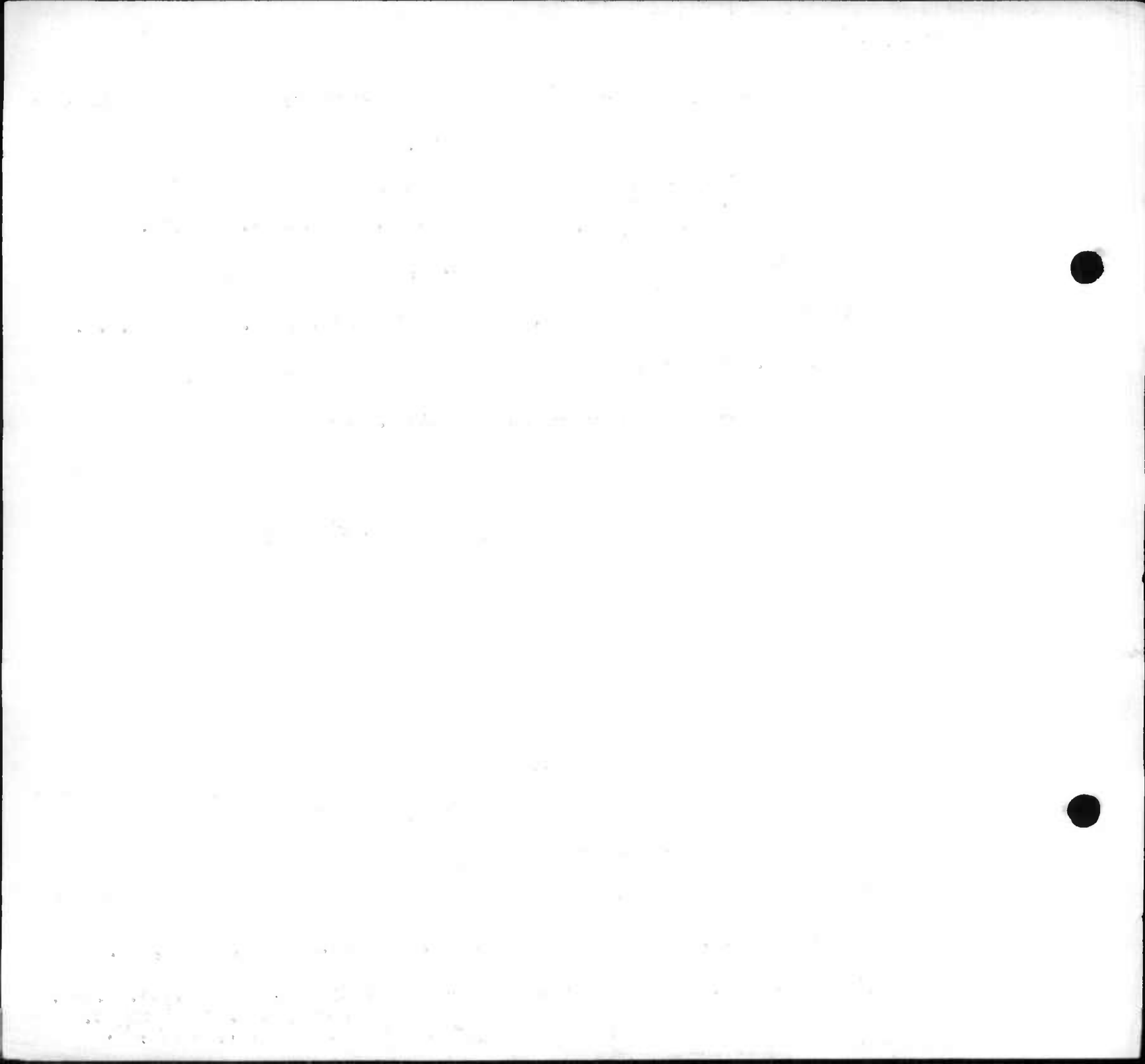
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		70 6608		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
DAVIES, MAE LARETTA				JUNE 28, 1970 7:35A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION				A. STATE		B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				MARYLAND		BALTIMORE		21207 5300	
40 ST. AGNES HOSPITAL				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		05 27 00		9. AGE (in years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House wife				Home		MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
WILLIAM SMITH				MAE (JACKSON)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
no						WILKENS AVES. BALTO., MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				PASS. PULMONARY EMBOLISM				3 days	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:				NOT ESTABLISHED.	
				ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NO				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
Month Day Year Hour		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (X) (this hospital) attended the deceased from JUNE 25 19 70 to JUNE 28 19 70 that (X) (we) last saw the deceased alive on JUNE 28 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
JULIO FREIJANES M.D.									
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
JULIO FREIJANES M.D.				CATON & WILKENS AVES. BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		7/1/70		Meadowridge		Elkridge		Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 1 1970		Robert E. Galt		John T. Stansbury, Sr.		-6411 Windsor Mill Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

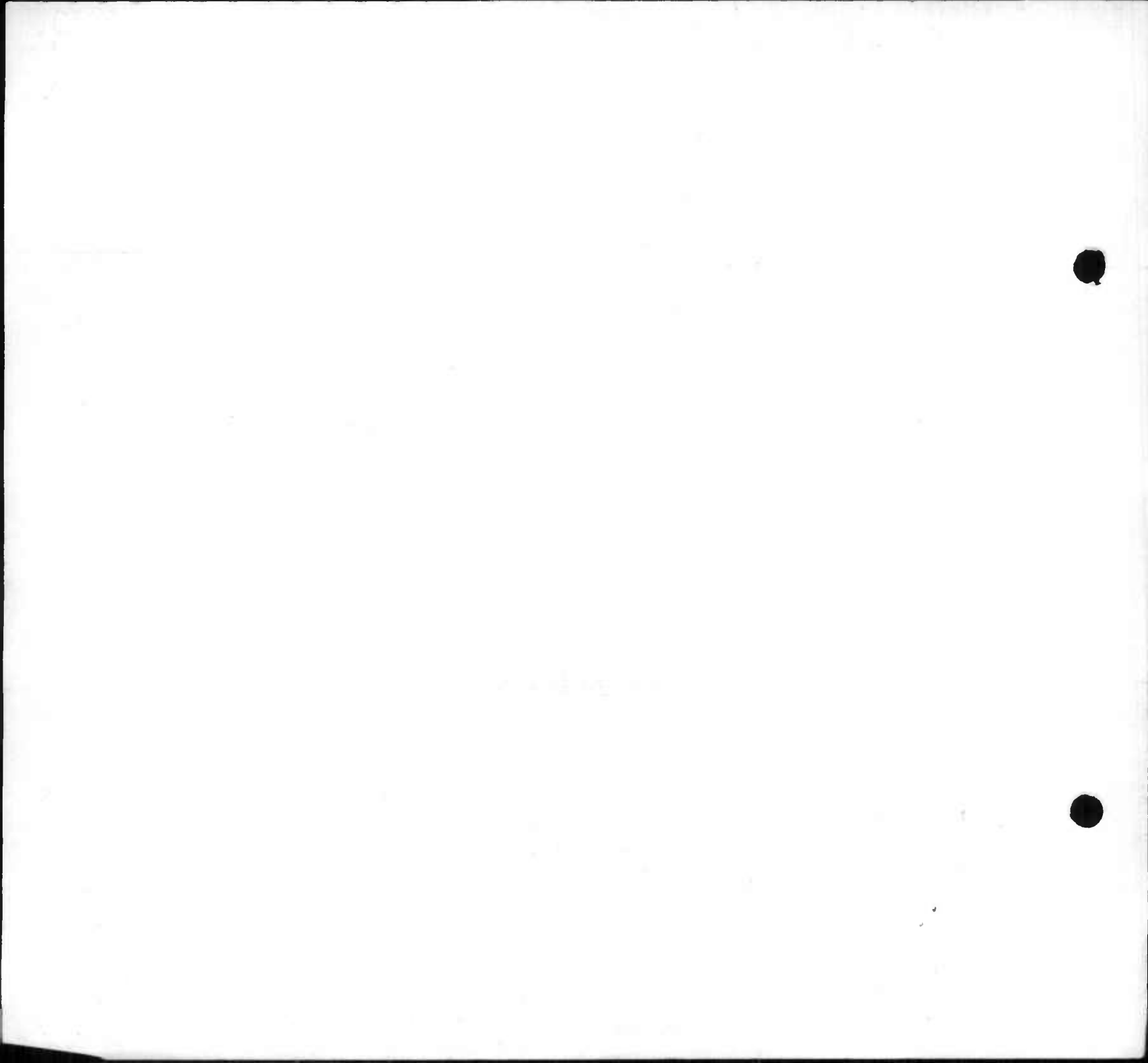
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6609</u>	
S-362 70 6609 BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN A. STRAUSBAUGH			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home and Hospital 100 N. Broadway Baltimore, Md.		2. DATE AND HOUR OF DEATH June 23, 1970 11:00 PM.			
5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2610			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Kimble-Tyler Co.		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 254 S. Bouldin St. # 21224.	
13. FATHER'S NAME John A. Strausbaugh		14. MOTHER'S MAIDEN NAME Alice Brewer			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-9871		17. INFORMANT Marie G. Strausbaugh ADDRESS Same	
18. 410.9 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Atherosclerosis					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/15 19 55 to 6/23 19 70 that (I) (we) last saw the deceased alive on 6/22 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Stuart D.P. Sunday				23B. DATE SIGNED 6/24/70	
23C. PHYSICIAN'S NAME (Type) STUART D.P. SUNDAY				23D. ADDRESS 201 E. 33rd St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-27-70.		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Ba. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970 25B. NAME OF REGISTRAR Robert E. Gabel 25C. FUNERAL DIRECTOR Robert E. Gabel ADDRESS 901 S. Conkling St. Balto., 21224, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

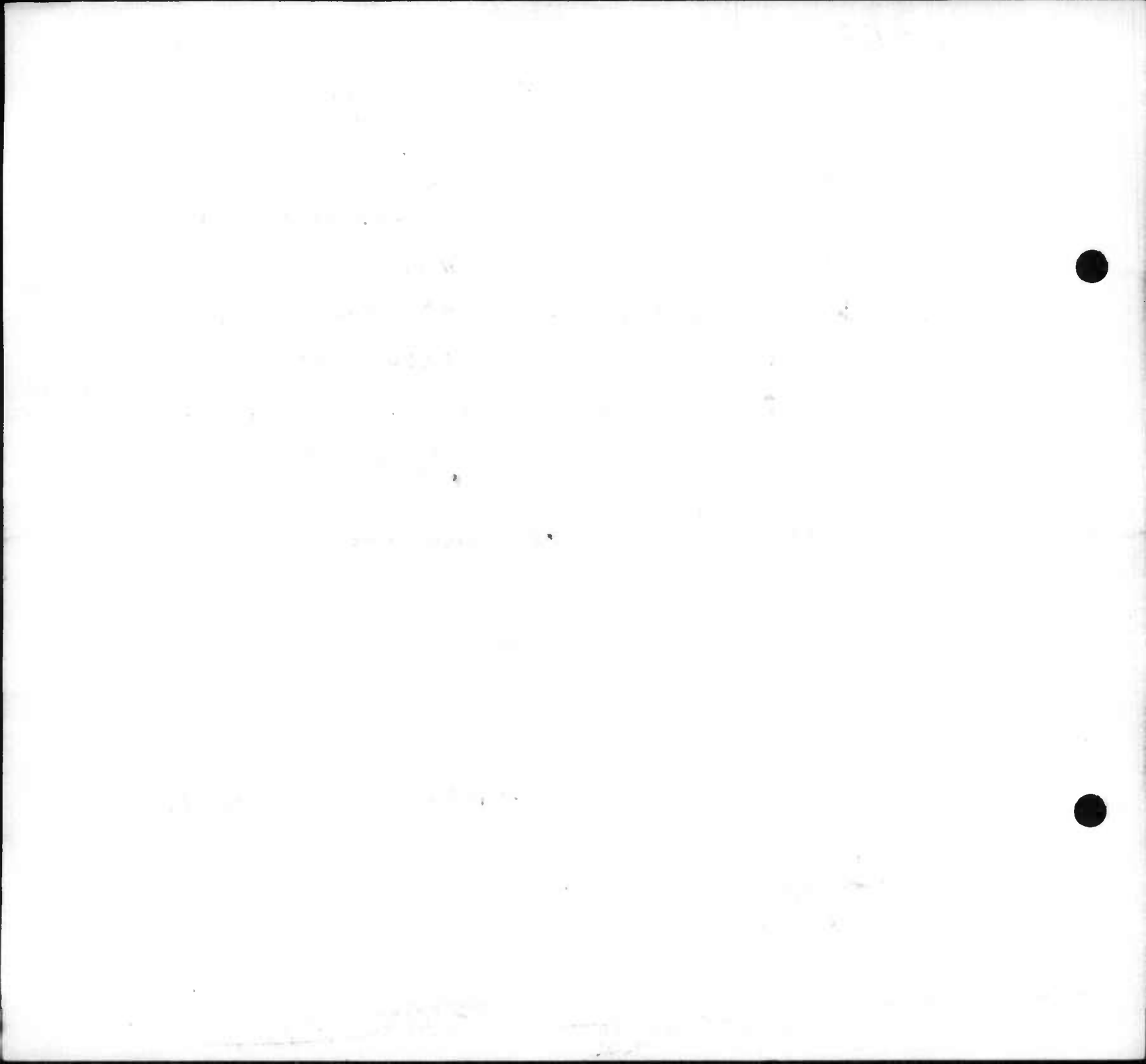
B-260 70 6610		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X 70 6610	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Baker Irma</i>		2. DATE AND HOUR OF DEATH <i>6/27/70 3:00 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bon Secours Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i> 6. RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>07/26/20</i> 9. AGE (in years last birthday) <i>49</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Howard Laisure</i>		14. MOTHER'S MAIDEN NAME <i>Ella McCain</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>219-22-9704</i>		17. INFORMANT <i>Charles A. Baker</i> ADDRESS <i>alone</i>	
18. <i>36791</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>generalized peritonitis.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 weeks.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>post operative infection.</i>			
19A. DATE OF OPERATION <i>5/27/70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>stomach incision</i>		20A. AUTOPSY? (Yes or No) <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/25/70</i> 19 <i>70</i> to <i>6/27</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>6/27</i> 19 <i>70</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Byong Hack Kim M.D.</i>		23B. DATE SIGNED <i>6/27/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Byong Hack Kim M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/1/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>London Park Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. NAME OF REGISTRAR <i>Robert E. Taylor</i>		24F. FUNERAL DIRECTOR <i>John J. Cowan</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>John J. Cowan</i>	



J-525 70 6611		BALTIMORE CITY HEALTH DEPARTMENT	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 6611	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <i>Minnie R. Jensen</i>		2. DATE OF DEATH Known <input type="checkbox"/> Month <i>6</i> Day <i>26</i> Year <i>70</i> Hour <i>11:25</i> P.M. Estimated <input checked="" type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>00318 Lehigh</i>		3. DATE PRONOUNCED DEAD Month <i>6</i> Day <i>27</i> Year <i>70</i> Hour <i>11:25</i> A.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2607</i>			
6. SEX <i>F</i>	7. RACE <i>W</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <i>Baltimore</i>
9. DATE OF BIRTH <i>8-4-1894</i>		10. AGE (In years last birthday) <i>75</i>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	E. STREET AND NUMBER <i>3185 Lehigh St.</i>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME <i>Mary Ann Spann</i>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No.</i>		17. SOCIAL SECURITY NO. <i>313-14-3133</i>	18. INFORMANT ADDRESS <i>Osmond Jensen, Jr. 7968 Cascade Heights Rd</i>
19. <i>4.12.71</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardiovascular Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION <i>0</i>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <i>WERNER U. SPITZ, M.D.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>6.28.70</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>6-30-70</i>	24C. NAME OF CEMETERY or CREMATORY <i>Meadowridge Mem. Pk</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1970</i>	25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>	25C. FUNERAL DIRECTOR <i>Elizabeth A. Hoffmann</i>	ADDRESS <i>3218 Hudson St</i>

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

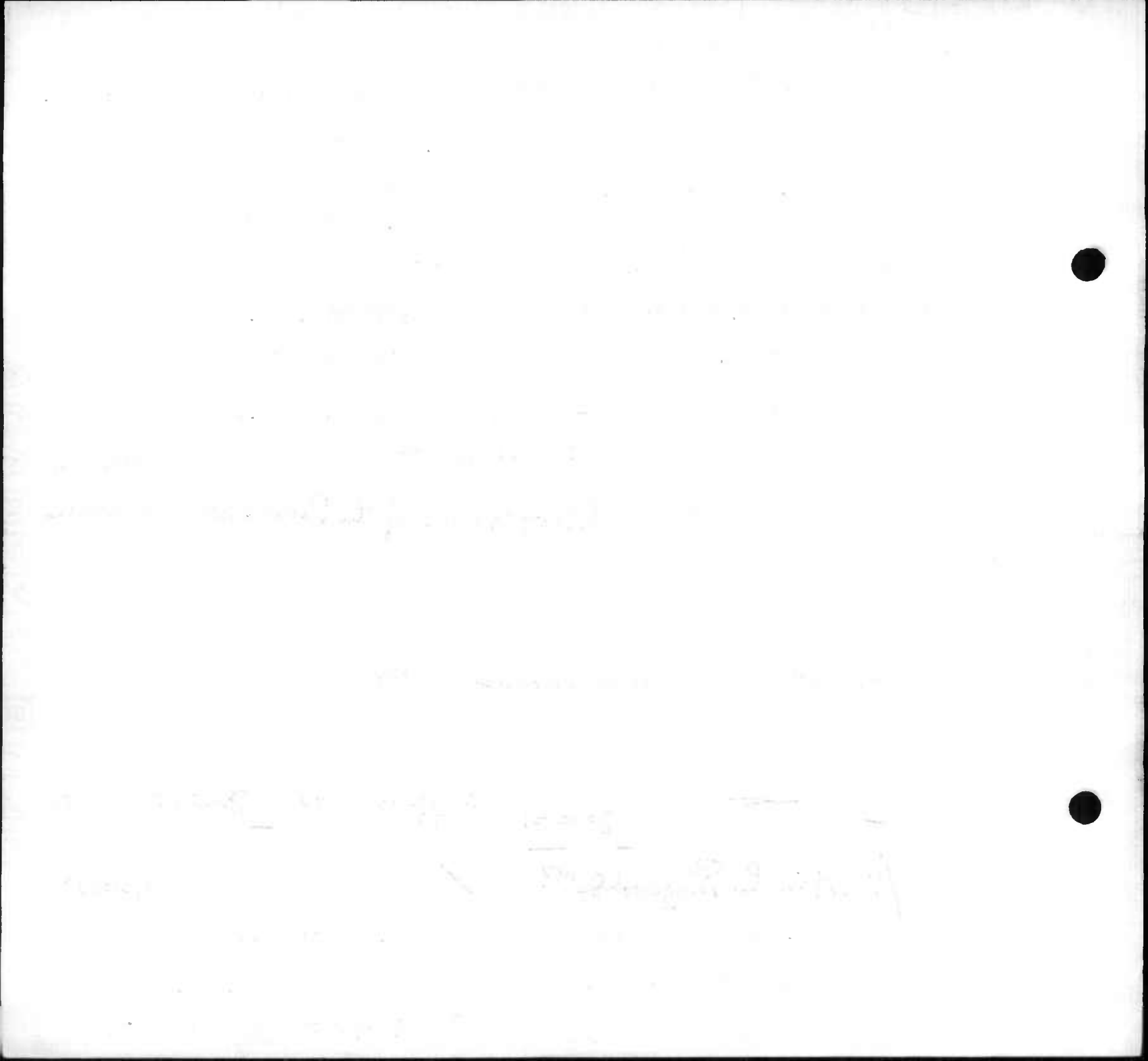
B-652 70 6612		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6612	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BARNES Mr. ARTHUR G.		2. DATE AND HOUR OF DEATH 6/25/70 10:45 Pm.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY 702		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION C.H. 4th SPITAL 35		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2424 E. Eager Street		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7/11/87		9. AGE (In years last birthday) 82 yr.		10. Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Candy Maker		10B. KIND OF BUSINESS OR INDUSTRY Virginia Dare		11. BIRTHPLACE (State or foreign country) MD. Broome Island	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LEVIN Barnes		14. MOTHER'S MAIDEN NAME ELLA Covington	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 21801 7969		17. INFORMANT Audrey B. Stevenson, dght. 3237 Dudley Av	
18. 53301 CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septic		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septic		(B) Septic DUE TO, OR AS A CONSEQUENCE OF:	
(C)		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/18/70 19 to 6/25/70 19 that (I) (we) last saw the deceased alive on 6/25/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. R. O. L. V.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) F. R. O. L. V.	
23D. ADDRESS		23E. ATTENDING PHYSICIAN Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23F. DEGREE	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 6/29/70		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		25D. ADDRESS 3331 Brehms Lane		25E. DATE OF DEATH 6/25/70	



FUNERAL DIRECTOR: IMPORTANT

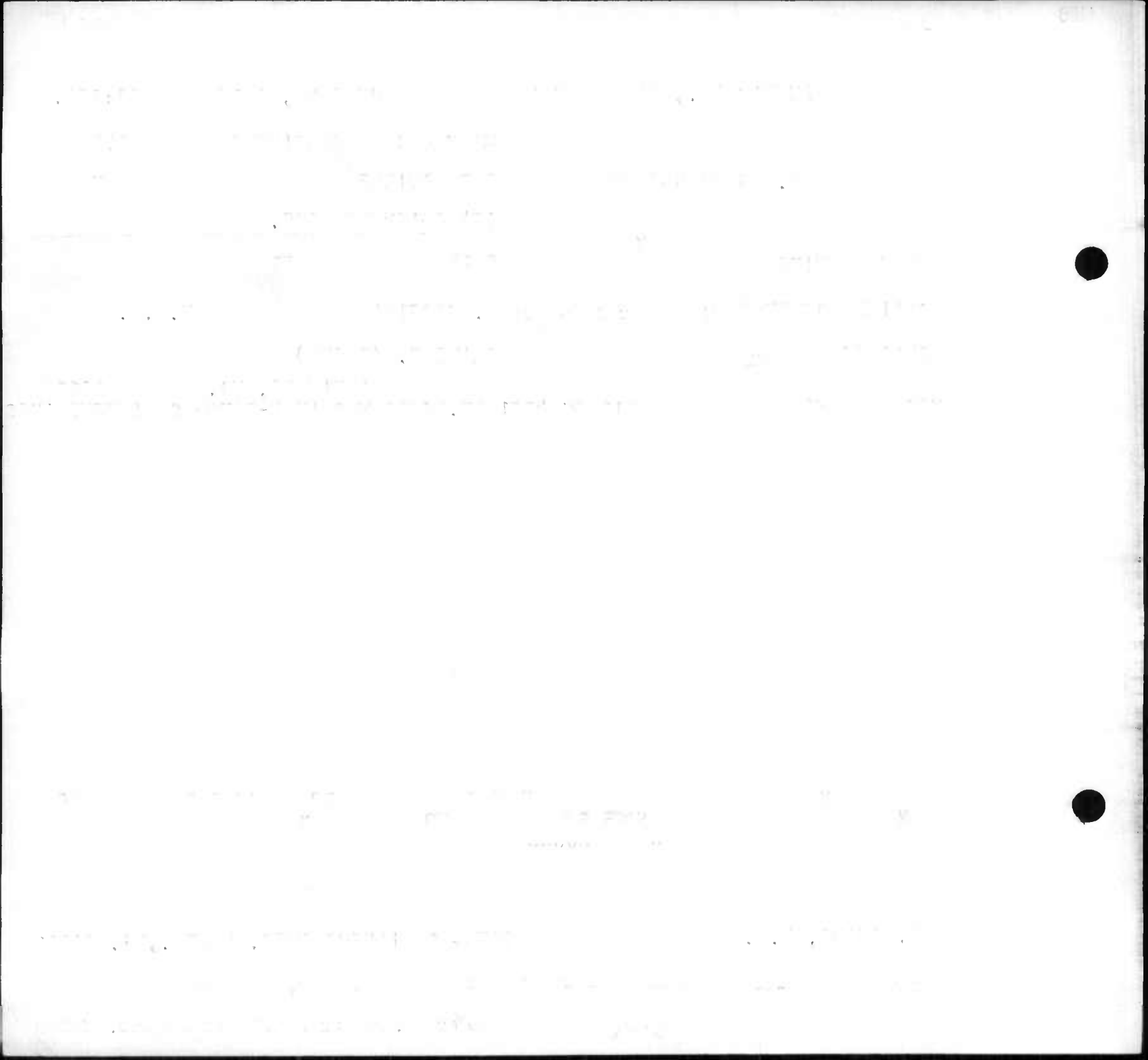
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-260		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6613	
BIRTH NO. 70 6613		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) AUGUST FERDINAND FISCHER		2. DATE AND HOUR OF DEATH June 25, 1970 9:30 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 409 N. Curley Street		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md., 21204 B. COUNTY 601 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 409 N. Curley Street			
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/19/96	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician-Amer.S		10B. KIND OF BUSINESS OR INDUSTRY Smelting & Refining		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME William E. Fischer		14. MOTHER'S MAIDEN NAME Rachel Morgan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service yes WW1 - Army		16. SOCIAL SECURITY NO. 212-10-1078		17. INFORMANT Ethel Fischer, dght., above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 137.9 I Carcinomatoris		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the Pancreas (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown	
19. DATE OF OPERATION MAY 10 1970		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Pancreas		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from March 12 1970 to June 25 1970 that (I) (we) last saw the deceased alive on June 21 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Martin L. Singewald M.D.		23B. DATE SIGNED 6/26/70		23C. ADDRESS 11 E. Chase St.,	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70		24C. NAME OF CEMETERY or CREMATORY Loudon Park	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR E. J. Jaber, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane	



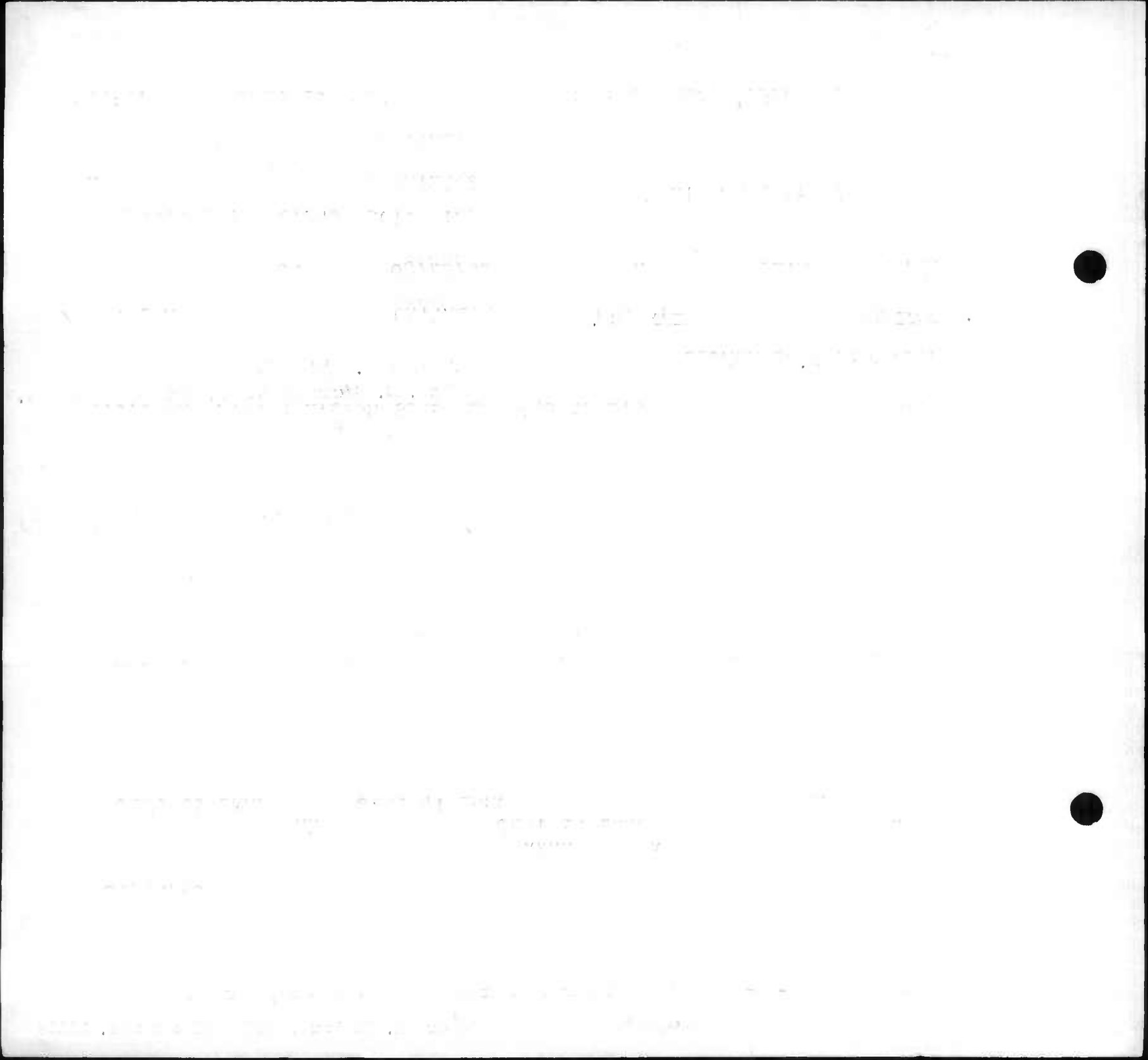
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-235		70 6614		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 6614	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
AUSTIN SR., EARL BOEHM				JUNE 28, 1970 11:30A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE 8. COUNTY			
ST. AGNES HOSPITAL				MARYLAND BALTIMORE 21228 5300			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
CATONSVILLE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER				104 SMITHWOOD AVE.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2 27 98	72			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CLAIMS ADJUSTOR		Tidewater Transport		W. VIRGINIA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES AUSTIN				OLIVE G. (BOEHM)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES WW1		212 09 4351		BALTIMORE, MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Possible Myocardial infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				2. Hemoptysis.			
				(C) Blood dyscrasias			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from JUNE 28 1970 to JUNE 28 1970 that (X) (we) last saw the deceased alive on JUNE 28 1970 and that in (NY) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
A. SHAMS, M.D.				6-28-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
A. SHAMS, M.D.		CATON & WILKENS AVES. BALTO., MD. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-1-1970		Lorraine Park Cemetery		Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 1 1970		Robert E. Taylor, Jr.		Howard H. Hubbard		4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

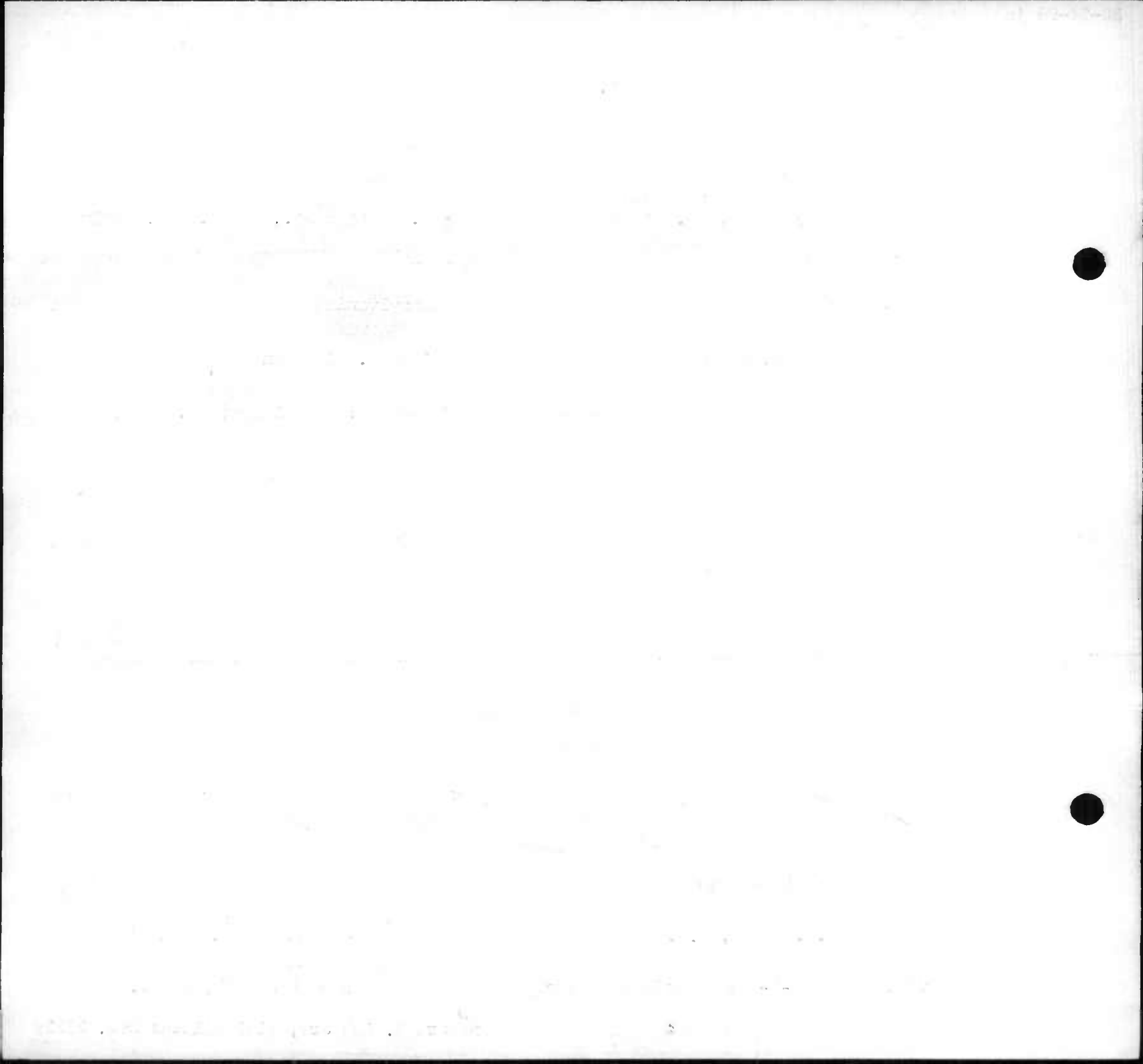
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6615</u>	
1. NAME OF DECEASED (Type or Print) <u>DE VOUGES, VICTOR JOSEPH</u>		2. DATE AND HOUR OF DEATH <u>JUNE 27 1970</u> <u>11:27AM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Catonsville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>601 MAIDEN CHOICE LANE 21228</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02/07/80</u>	9. AGE (In years last birthday) <u>90</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SWIFT & CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>ALPHONSE A. DE VOUGES</u>		14. MOTHER'S MAIDEN NAME <u>THERESA M. O'FARRELL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215 07 0489</u>		17. INFORMANT <u>Mrs. E. Gertrude Lewns, 406 Montemar Ave. ST AGNES HOSPITAL BALTO MD 21229</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>GENERALIZED PERIPHERAL ARTERIAL DISEASE.</u>					
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JUNE 14 1970</u> 19 to <u>JUNE 27 1970</u> 19 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JUNE 27 1970</u> 19 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
23A. SIGNATURE <u>Julio Treinanes M.D.</u>		23B. DATE SIGNED <u>06/27/70</u>		23C. PHYSICIAN'S NAME (Type) <u>JULIO TREINANES</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6-30-1970</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

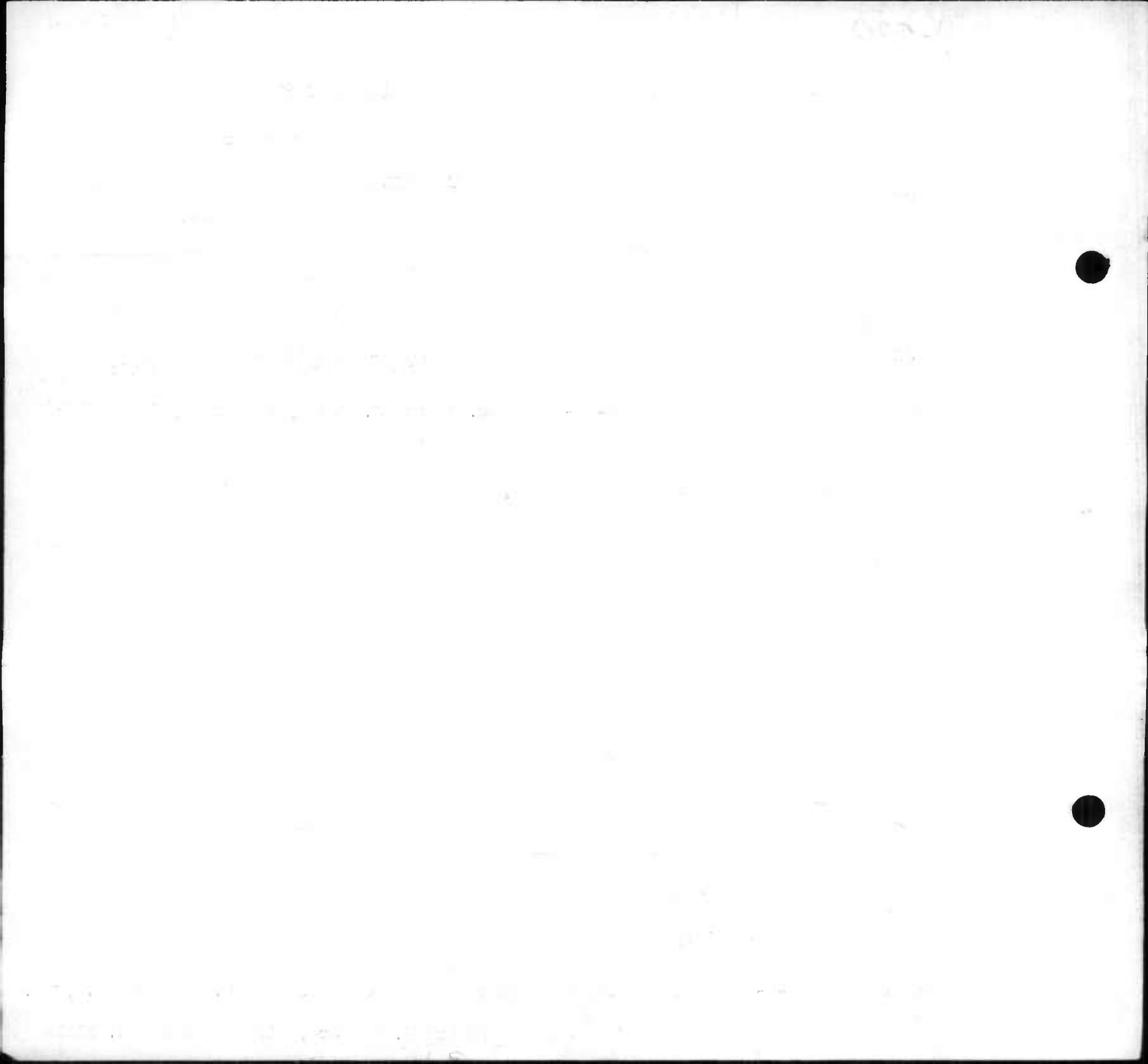
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
S-512 70 6616		CERTIFICATE OF DEATH		70 6616	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Elizabeth E. Simpson		6/28/70 9 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. 21224		A. STATE Maryland B. COUNTY 1206			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 11-13-80	
13. FATHER'S NAME Miles O. Everhart		14. MOTHER'S MAIDEN NAME Alice B. Hirleman		9. AGE (In years last birthday) 89	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-52-0734		11. BIRTHPLACE (State or foreign country) Pennsylvania	
17. INFORMANT BCH Records: Baltimore, Md. 21224		12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 4124 1-1841 Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD CAUSE OF DEATH Pneumonia DUE TO, OR AS A CONSEQUENCE OF: ASCVD DUE TO, OR AS A CONSEQUENCE OF: Ca of vulva APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3d. 4 years 2 yrs		19. DATE OF OPERATION 0		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 1/30/67 to 6/28 19 70 that (H) (we) last saw the deceased alive on 6/28 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.		23A. SIGNATURE J.R. Neefe M.D.		23B. DATE SIGNED 6/28/70	
23C. PHYSICIAN'S NAME (Type) J.R. Neefe, M.D.		23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave., Balto., Md. 21224		24. LOCATION (City, town, or county) (State) Jackson Township Columbia County, Penna.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-1970		24C. NAME OF CEMETERY or CREMATORY Waller Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

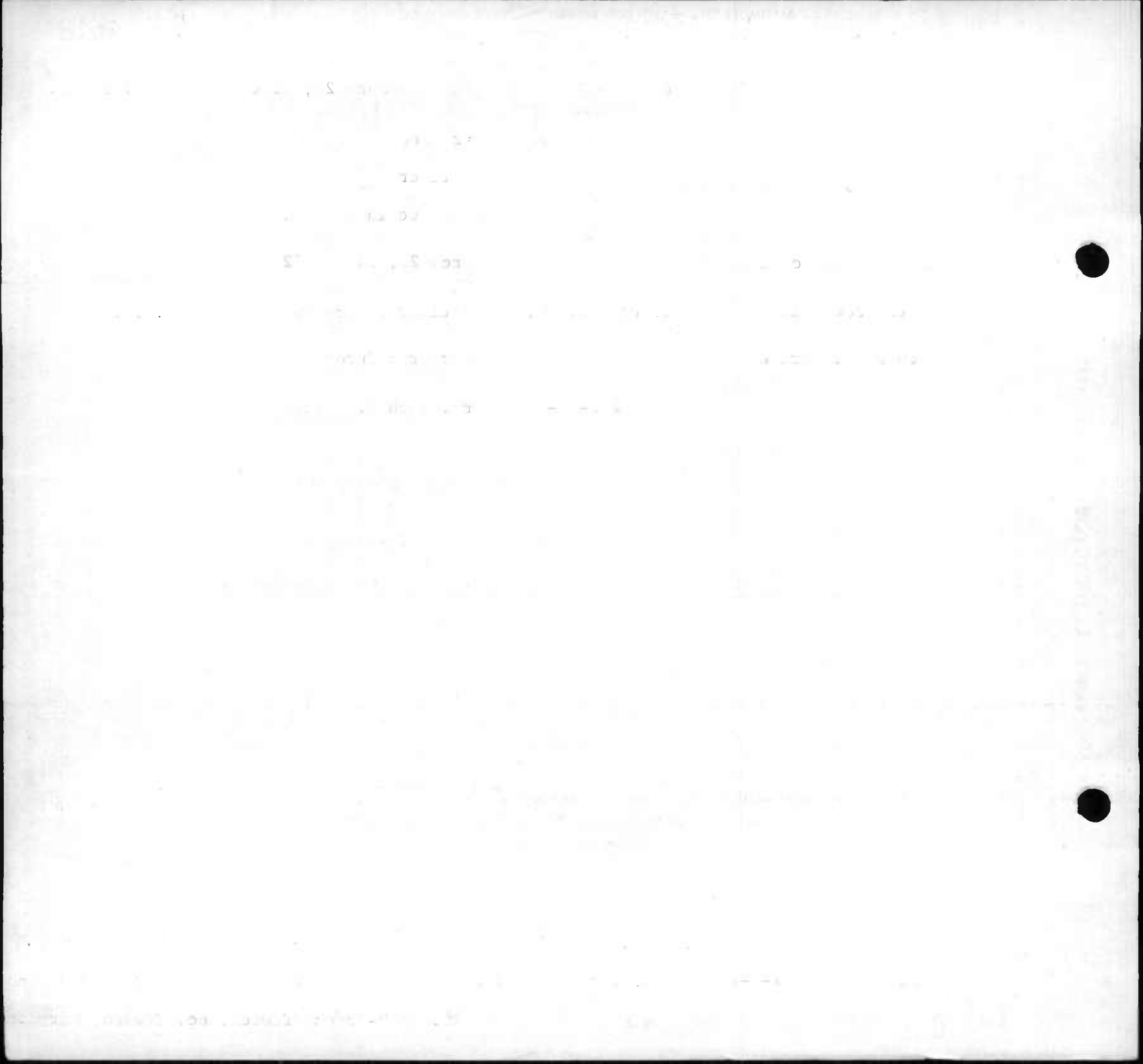
Y-520		70 6617		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 6617	
1. NAME OF DECEASED (Type or Print) EVELYN YOUNG				2. DATE AND HOUR OF DEATH June 28 1970 10 28 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND 38 HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore 5300			
5. SEX F 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 4/26/15		9. AGE (In years last birthday) 55	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME 8 IMON STEPHEN				14. MOTHER'S MAIDEN NAME XXXXXXXXXXXXXXXXXXXX Anna Meizis			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-14-9640		17. INFORMANT ADDRESS Mr. Edward J. Young, 515 Crosby Road 21228	
18. 2022/1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE CEREBRAL EMBOLISM DUE TO, OR AS A CONSEQUENCE OF:		21 hrs	
				(B) Left ATRIAL MYXOMA DUE TO, OR AS A CONSEQUENCE OF:		18 months	
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3/6/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARDIAC CATH. - DX.		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that it (this hospital) attended the deceased from 6/2 19 70 to 6/28 19 70 that it (we) last saw the deceased alive on 6/28 19 70 and that it (we) (our) opinion death occurred on the date and hour and from the causes stated above. it (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jane E. Mahaffey M.D.				23B. DATE SIGNED 6/28/70		23C. PHYSICIAN'S NAME (Type) JANE E. MAHAFFEY M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-1-70		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Washington Blvd., Howard Co., Md.				25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970			
25B. NAME OF REGISTRAR Howard H. Hubbard				25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

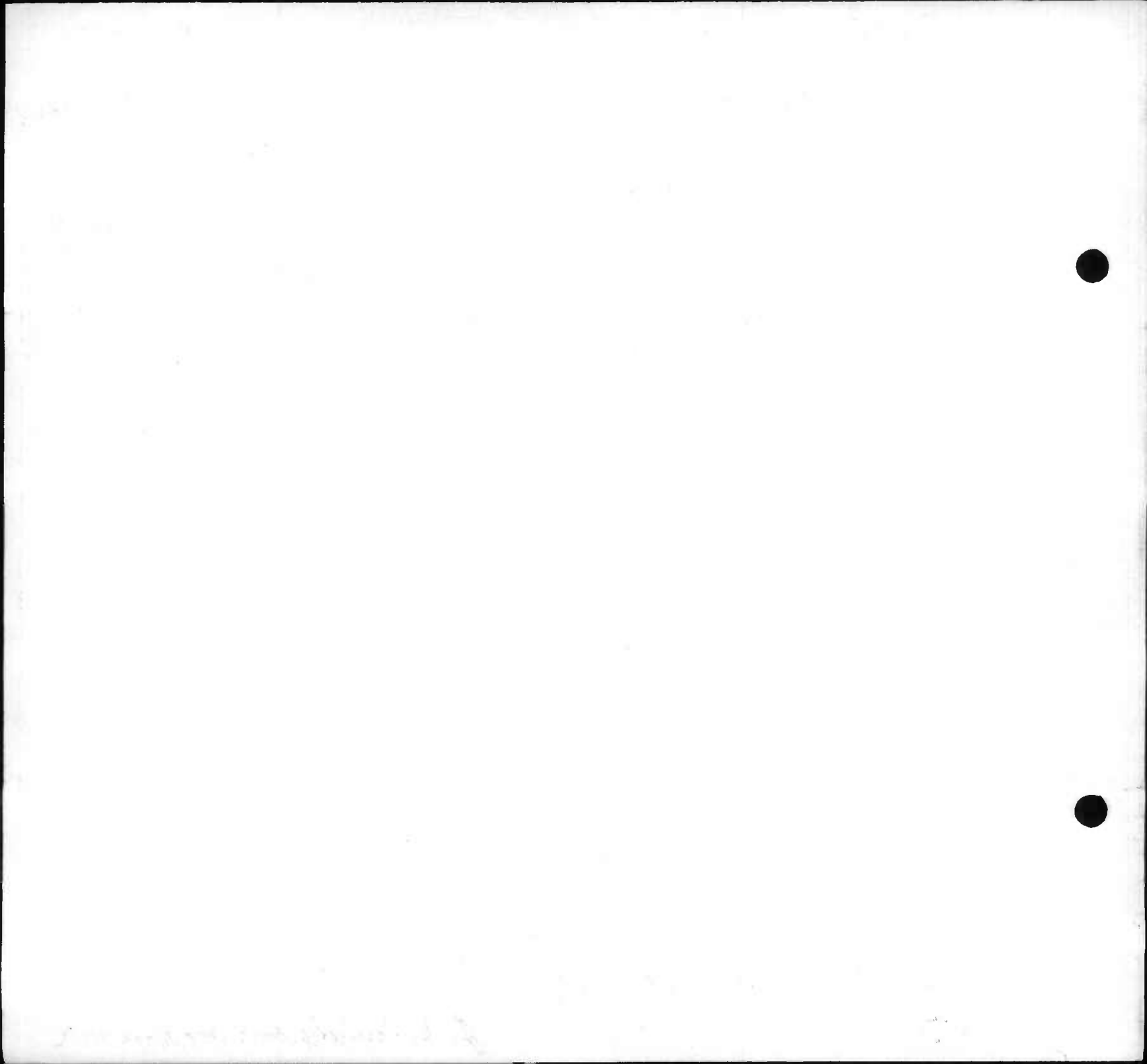
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6618	
B-635 70 6618 BIRTH NO. 1. NAME OF DECEASED (Type or Print) HOWARD EUGENE BURTON		2. DATE AND HOUR OF DEATH June 28, 1970 1:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hood Convalescent Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3713 Buckingham Rd.			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1908	9. AGE (In years last birthday) 62	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Data Processing
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard C. Burton		14. MOTHER'S MAIDEN NAME Margaret Turnbaugh			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-09-1103		17. INFORMANT Mrs. Ruth E. Burton	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 1. 62, 1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <i>BRONCHIOGENIC CARCINOMA</i> DUE TO, OR AS A CONSEQUENCE OF: 2. CENTRAL METASTASIS (B) N. C. LUNGARY SYMPTOMAT. METASTASIS DUE TO, OR AS A CONSEQUENCE OF: (C) CRIBRARY T. ACET. L. ACET.			
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6/1 1970 to 6/28 1970, that (I) (we) last saw the deceased alive on 6/28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 6/19/70	
23C. PHYSICIAN'S NAME (Type) J. Edgar H. Shiner, M.D.		23D. ADDRESS 8800 E. MONTGOMERY AVE. BALTO. MD 21228			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-70		24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	
24D. LOCATION (City, town, or county) Hereford		24E. BALTIMORE Maryland			
25A. DATE RECD. BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Barber, M.D.		25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc. Towson, Maryland	



FUNERAL DIRECTOR: IMPORTANT

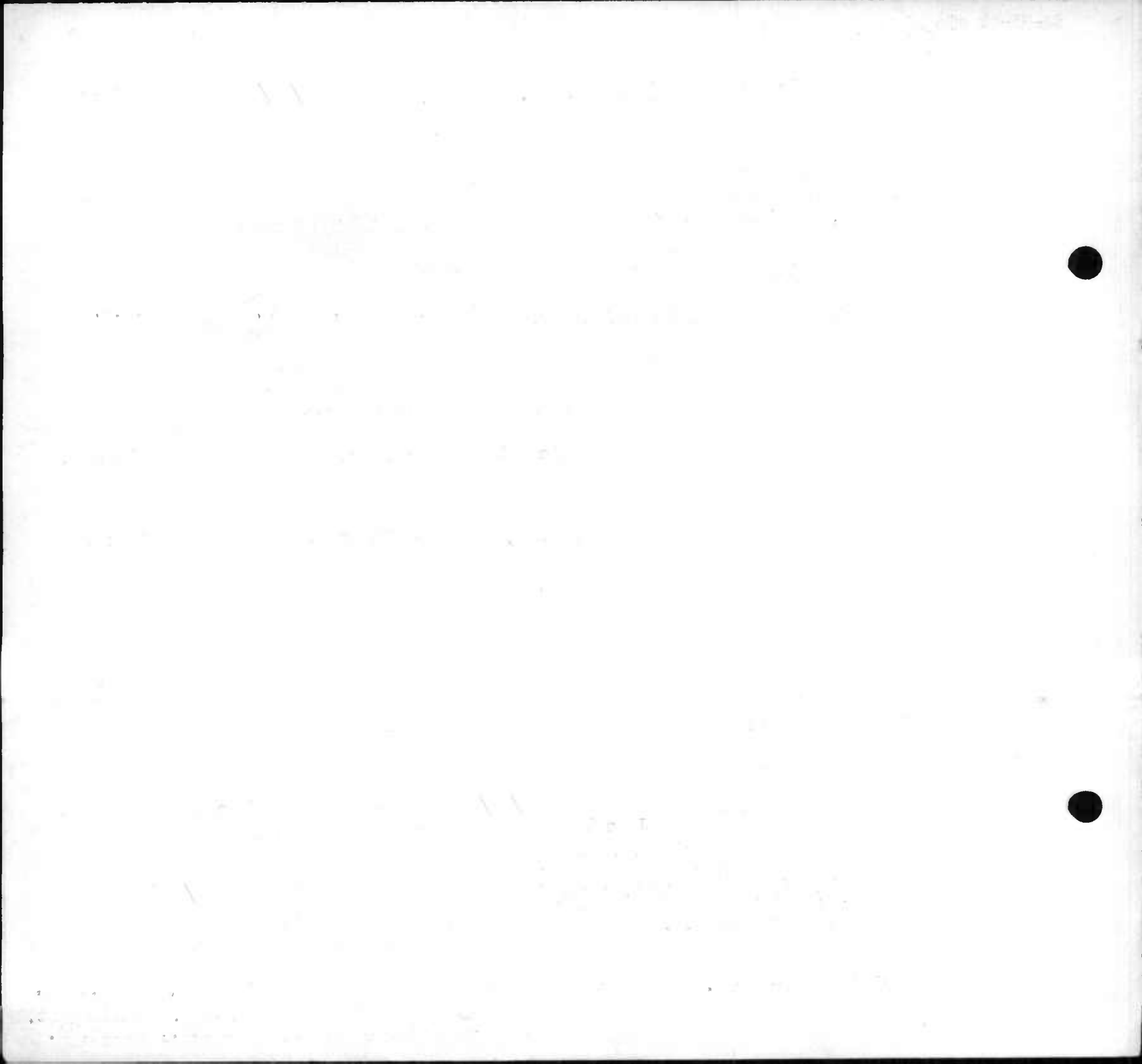
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-360 70 6619		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6619
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Sutor, Stehlae M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>6-26-70</u> <u>1945 A.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME AND HOSPITAL</u> <u>35</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>406 CRISFIELD RD. 21220</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-10</u>	9. AGE (in years last birthday) <u>60</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>RUBIN ALGER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>217 012496</u>		17. INFORMANT <u>Richard S. Sutor/Hyattsville</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>412417-25019</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac arrest</u> <u>ASCVD, Anemia, Diabetes mellitus</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Deep vein thrombosis, Hypoalbuminemia</u> (C) <u>—</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>6/13</u> 19 <u>70</u> to <u>6/26</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6/26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>A.C. Chouvalit, M.D.</u>		23B. DATE SIGNED <u>6/26/70</u>		23C. PHYSICIAN'S NAME (Type) <u>A.C. CHOUVALIT, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>June 29, 1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holly Hill</u>
24D. LOCATION (City, town, or county) (State) <u>Balto Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Baker, M.D.</u>		25C. FUNERAL DIRECTOR <u>J. S. Connolly, 300 Maple Ave</u>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

54-95-61 d		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6620	
<p>BIRTH NO. <u>K-510</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>Charles Knaub</u> (<u>CHARLES H. KNAUB</u>)</p>		<p>70 6620</p> <p>CERTIFICATE OF DEATH</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u></p>		<p>2. DATE AND HOUR OF DEATH <u>6/23/70</u> <u>10:00 A</u> M.</p> <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2607</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>504 South Lehigh Street</u> <u>21224</u></p>			
<p>5. SEX <u>Male</u></p>	<p>6. RACE <u>White</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>10-31-13</u></p>	<p>9. AGE (In years last birthday) <u>56</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>White Coffee Pot</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Pennsylvania, York.</u></p>	
<p>13. FATHER'S NAME <u>Knaub</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Unknown</u></p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>453-32-5565</u></p>		<p>17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH: Records Baltimore, Maryland 21224</u></p>	
<p>18. CAUSE OF DEATH</p>					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>204.1 I</u> <u>Bacterial and Fungus Sepsis</u></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE <u>DUE TO, OR AS A CONSEQUENCE OF:</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u></p>	
<p>ANTECEDENT CAUSES <u>II</u> <u>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,</u></p>		<p>(B) Chronic Lymphatic Leukemia <u>DUE TO, OR AS A CONSEQUENCE OF:</u></p>		<p><u>1 year</u></p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <u>2-</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u></p>		<p>20A. AUTOPSY? (Yes or No) <u>Yes</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> <u>no</u></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u></p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u></p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-</u></p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <u>-</u></p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>4/20/70</u> <u>1970</u> to <u>June 23</u> <u>1970</u> that (I) (we) last saw the deceased alive on <u>June 23</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Marc Colmer M.D.</u></p>				<p>23B. DATE SIGNED <u>6/23/70</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>Marc Colmer M.D.</u></p>		<p>23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u></p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>6-30-70.</u></p>		<p>24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u></p>	
<p>24D. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave. Balto., Md.</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u> 25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u> 25C. FUNERAL DIRECTOR <u>Charles S. Feiler</u> ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u></p>			



W-260⁷⁰

6621

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

6621

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BERTHA WEISER

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Levindale Nursing Home 8-14-70

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

6

26

1970

2:40 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

6. SEX

Female

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Owings Mill

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

Jan 31, 1901

10. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

HarMonr

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Bernard

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Nurse

14B. KIND OF BUSINESS OR INDUSTRY

Nursing Home

15. MOTHER'S MAIDEN NAME

Bella

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Hosp Chart

ADDRESS

19.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Subdural and intracerebral

(A) IMMEDIATE CAUSE

Septic

hemorrhage

DUE TO, OR AS A CONSEQUENCE OF:

(B)

~~pneumonia~~

DUE TO, OR AS A CONSEQUENCE OF:

(C) ~~subdural and intracerebral hemorrhage~~APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Arteriosclerotic cardiovascular disease

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Harmonr Owings Mill, Md.

22D. TIME
OF INJURY
(APPROX.)

3-?-70

?

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

Fell at home.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-26-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

6/29/70

24C. NAME OF CEMETERY or CREMATORY

Mt Judah

24D. LOCATION (City, town, or county)

Brooklyn New York

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1970

25B. NAME OF REGISTRAR

Robert E. Bailey

25C. FUNERAL DIRECTOR

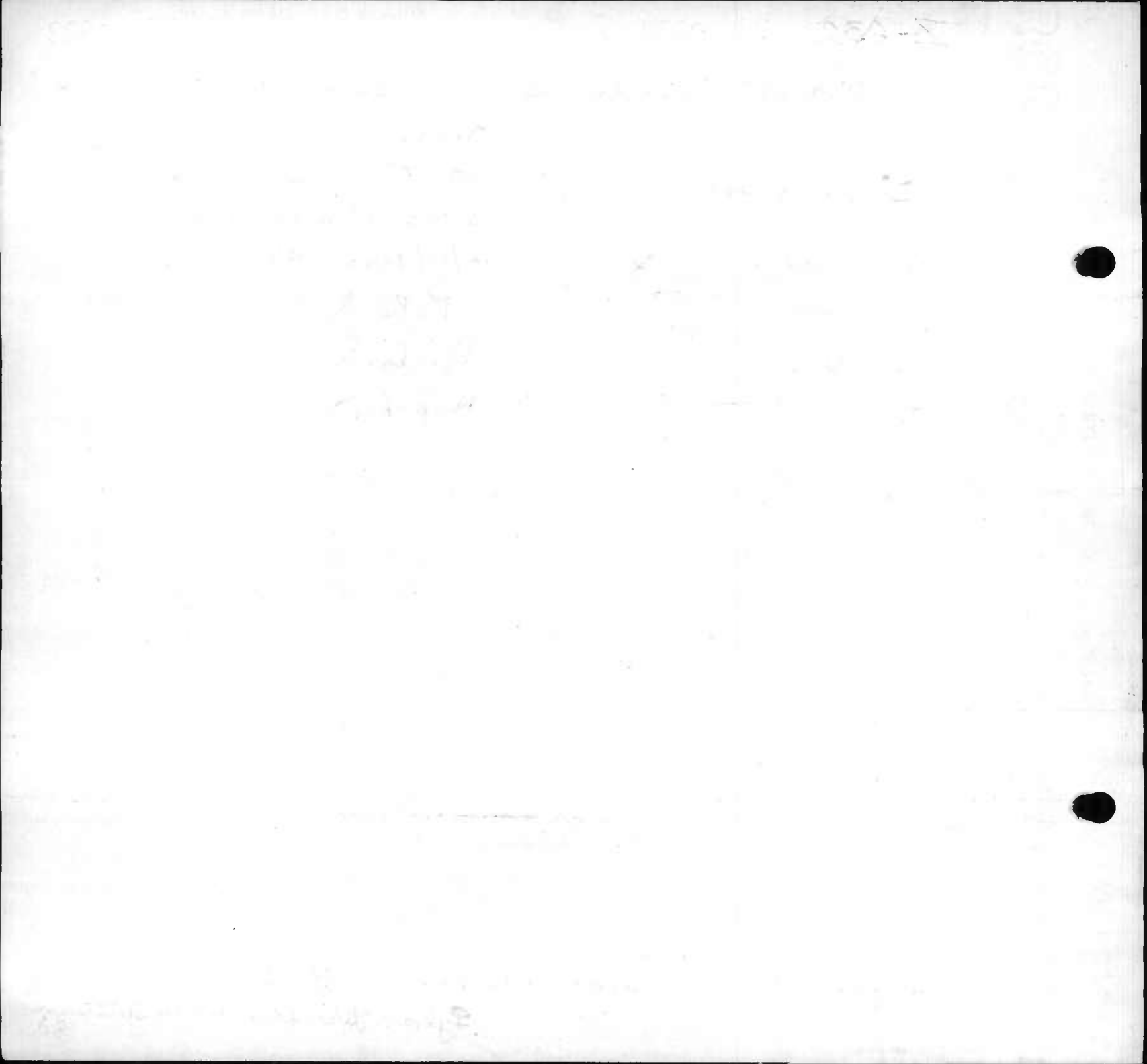
Sylvan Lewis & Son 9610 Reisterstown Rd

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

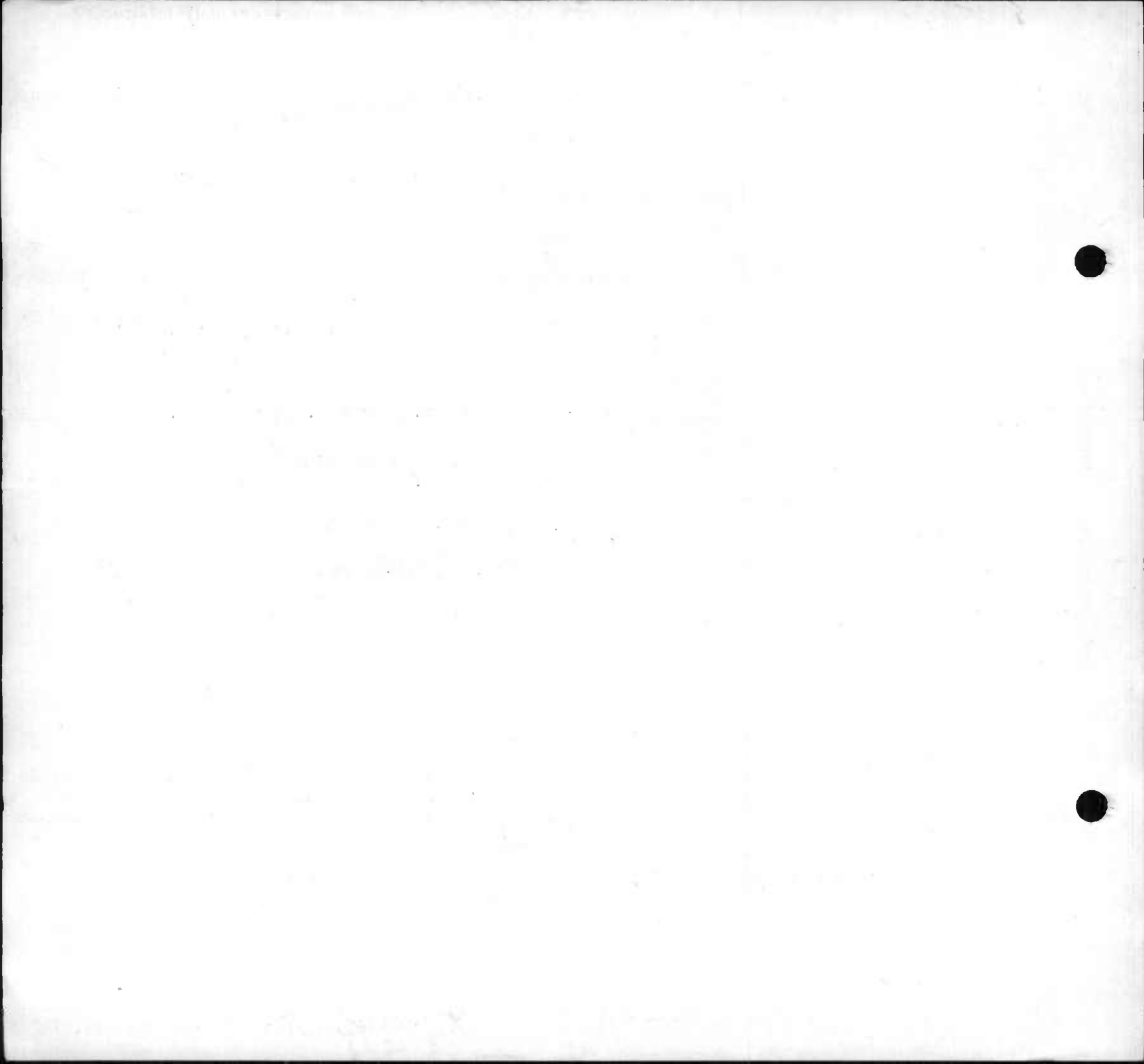
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6622</u>	
Z-632 70 6622		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MOHLIE ZERVITZ</u>		2. DATE AND HOUR OF DEATH <u>June 27, 1970 9:00 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>42 Sinai Hosp</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>2740</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 Sinai Hosp</u>		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5913 Winner Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/1883</u>	9. AGE (In years last birthday) <u>86</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>Sander</u>		14. MOTHER'S MAIDEN NAME <u>Rebecc</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp chart</u>	
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 17</u> 19 <u>67</u> to <u>July 27</u> 19 <u>70</u> ; that (I) (we) last saw the deceased alive on <u>July 26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>Leon S. Sheer M.D.</u>		23B. DATE SIGNED <u>6/28/70</u>		23C. PHYSICIAN'S NAME (Type) <u>LEON SHEER, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>6/28/70</u>		24C. NAME of CEMETERY or CREMATORY <u>B'nai Israel</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Sylvan L. Liss & Son</u>		25D. ADDRESS <u>9610 Reisterstown Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

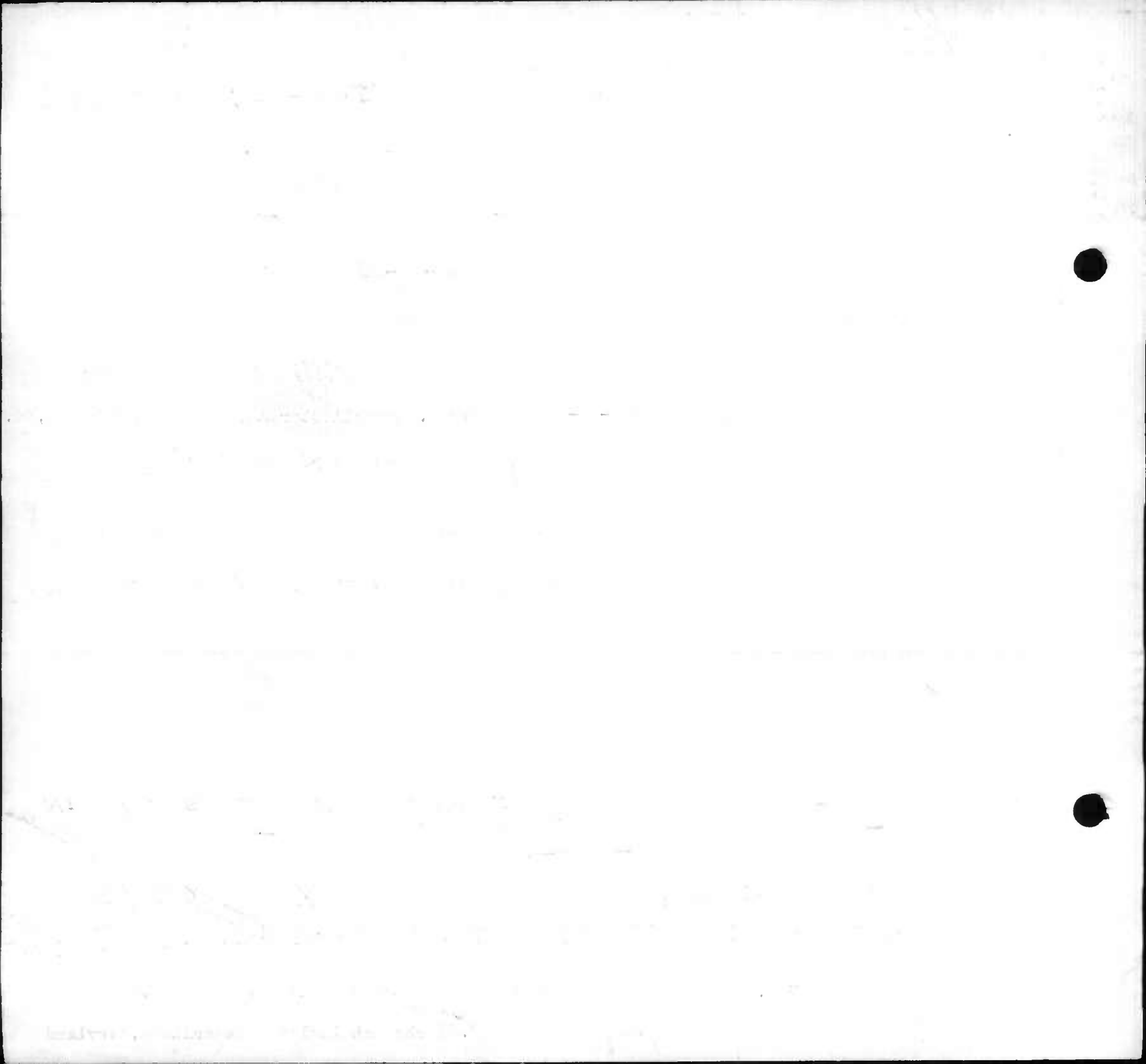
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-450		70 6623		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6623	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Anna Klein (Anna Viole Klein)</i>				2. DATE AND HOUR OF DEATH <i>6/29/70 4:55 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>ANNE ARUNDEL</i>			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? <i>XXXXXX</i> NO <input checked="" type="checkbox"/>	
<i>3 South Baltimore General</i>						E. STREET AND NUMBER <i>111 W. 15th Ave</i>		<i>21225</i>	
5. SEX <i>Fe</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-24-01</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Johnson</i>				14. MOTHER'S MAIDEN NAME <i>MARY GRAY</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-20-8088-B</i>		17. INFORMANT <i>Mr. George E. Klein</i>		ADDRESS <i>111 W. 15th Ave. 21225</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>myocardial infarct</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>coronary heart disease</i> (C) <i>atherosclerosis</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>6-28</i> 19 <i>70</i> to <i>6-29</i> 19 <i>70</i> , that (I) (we) lost saw the deceased alive on <i>6-29</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Nabel Yacoub Younan</i>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>NABEL YACOB Younan</i>						23D. ADDRESS <i>South Baltimore General Hospt.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/3/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Glen Haven Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Glen Burnie Anne Arundel County, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>M. Cully F. H.</i>		ADDRESS <i>237 Patapsco Ave. 21225</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

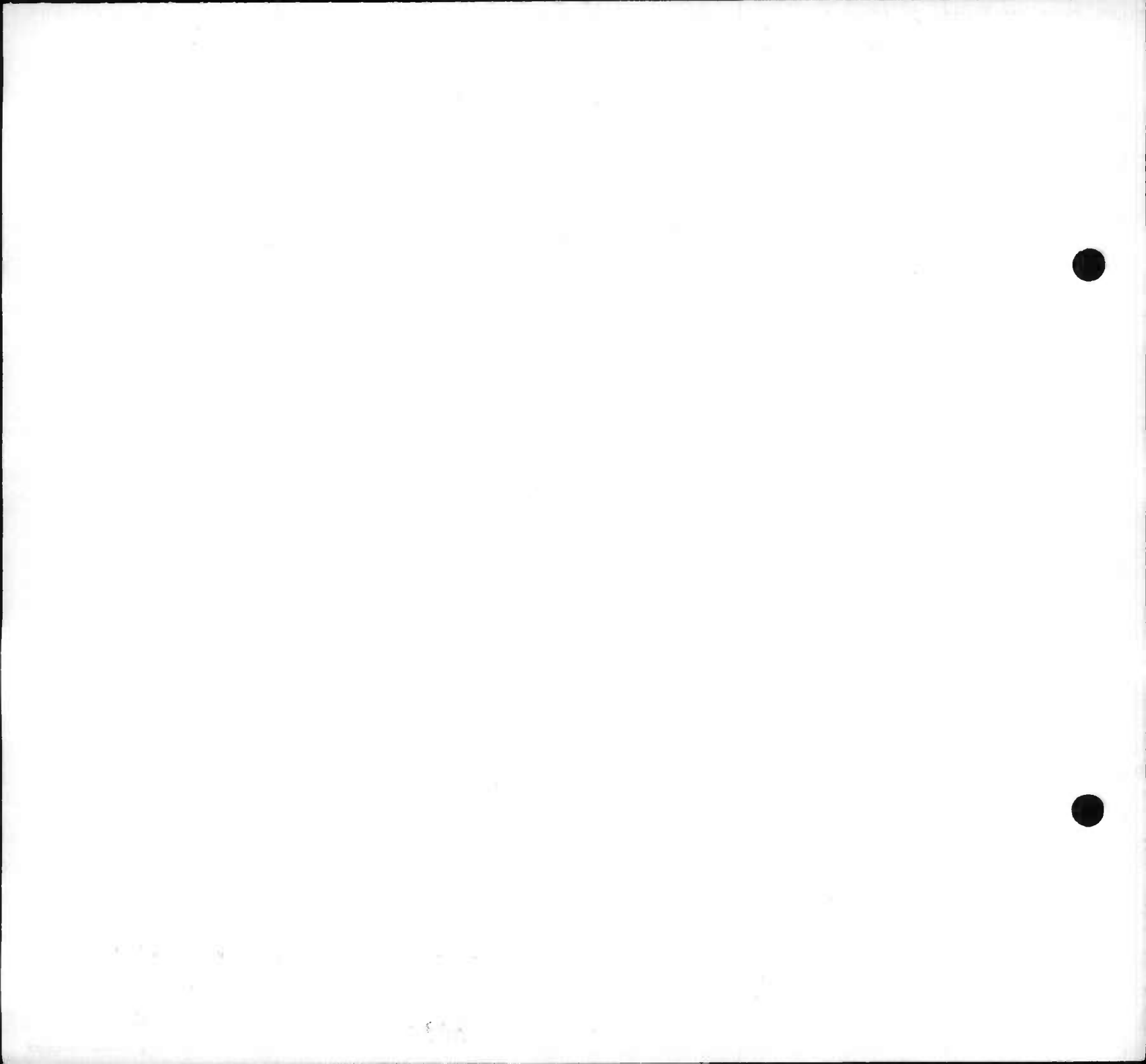
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6624</u>	
BIRTH NO. <u>70 6624</u>		1. NAME OF DECEASED (Type or Print) <u>THEODORE RUSSELL</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>JUNE 27 1970 7:45 P.M.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>ST. MARYS</u>		C. CITY OR TOWN <u>CALIFORNIA</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>THEODORE RUSSELL</u>		14. MOTHER'S MAIDEN NAME <u>ANN PEAKTON Elizabeth Pilkerton</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW1</u>		16. SOCIAL SECURITY NO. <u>216-09-6237</u>		17. INFORMANT ADDRESS <u>Mary M. Russell Star Rt, Box 553 California, Md.</u>	
18. <u>5-17X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCTION</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ANOXIA</u> <u>HAMMAN RICH SYNDROME</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>2 months</u> <u>3 months</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>JUNE 8 1970</u> to <u>JUNE 27 1970</u> that (I) (we) last saw the deceased alive on <u>JUNE 27 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>NF Adkinson MD</u>		23B. DATE SIGNED <u>6/27/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>NF ADKINSON JR M.D.</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL BALTIMORE MD 21205</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>6/1/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Face Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Great Mills, St Mary's, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		24F. NAME OF REGISTRAR <u>Robert E. Taylor, Md.</u>	
24G. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>		24H. ADDRESS <u>Leonardtown, Maryland</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 6625	
E-352 BIRTH NO. 70-090730 6625				1. NAME OF DECEASED (Type or Print) Baby Boy Edens		2. DATE AND HOUR OF DEATH 6/25/70 1:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE 1603 Normal Avenue 805 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/3/70	9. AGE (In years last birthday) 23	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charles Cole		14. MOTHER'S MAIDEN NAME Cynthia Edens		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Cynthia Edens ADDRESS		
18. 772.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Intracranial bleeding(?) (B) Prematurity DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 3 19 70 to June 25 19 70 that (I) (we) last saw the deceased alive on June 25 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Shih-Wen Huang, M.D.				23B. DATE SIGNED June 25, 70		23C. PHYSICIAN'S NAME (Type) SHIH-WEN HUANG, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) 6-29-70				24B. DATE 6-29-70		24C. NAME OF CEMETERY or CREMATION LOCATION ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BORD	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6626
8-320 BIRTH NO. 70-10463 1. NAME OF DECEASED (Type or Print) Baby Boy Shoats		2. DATE AND HOUR OF DEATH June 21, 1970 11:30 PM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 802 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1734 Milton Ave, Balto. #13		
5. SEX Male 6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21 9. AGE (In years last birthday) 7 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 21 3		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Herbert Shoat		14. MOTHER'S MAIDEN NAME Doralee Little		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Doralee Little ADDRESS
18. 746.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 21 19 70 to June 21 19 70 that (I) (we) lost saw the deceased alive on June 21 19 70 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Shih-Wen Huang MD		23B. DATE SIGNED June 21, 1970		23C. PHYSICIAN'S NAME (Type) SHIH-WEN HUANG M.D.
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 6-29-70 24C. NAME OF CEMETERY or CREMATOR		
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Fisher, MD.		
ANATOMY BOARD OF MARYLAND UNIVERSITY OF MARYLAND MEDICAL SCHOOL MORTUARY SERVICE - BOND				

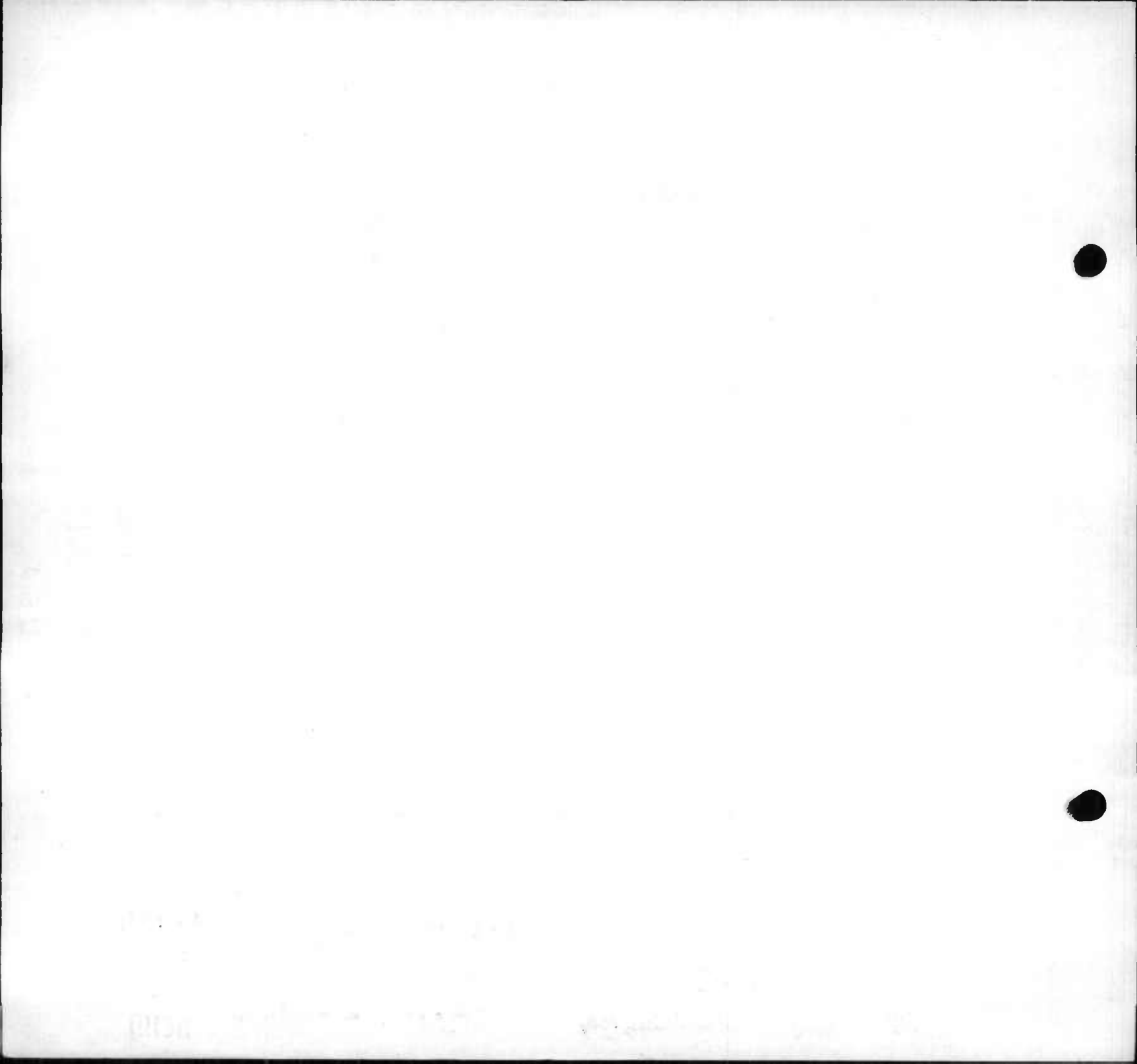


Replace for first certification which is lost.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>70 6627</u>	
BIRTH NO. <u>D-635</u>		70 6627		CERTIFICATE OF DEATH							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mildred Darden</u>				2. DATE AND HOUR OF DEATH <u>6/15/70</u> <u>3:50 A</u> M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hosp.</u>				A. STATE <u>MD.</u>				B. COUNTY <u>Balto.</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN <u>Balto.</u>				(If outside city limits, write RURAL and give township)			
				D. STREET ADDRESS <u>2503 Madison Ave. Apt #2</u>				(If rural, give location)			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <u>10/4/1913</u>		9. AGE (In years last birthday) <u>56</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS		
18. <u>199.0 I</u>				CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) <u>Metastatic Carcinoma</u>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>DUE TO</u>							
				(C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> 19 <u>70</u> to <u>6/15</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>6/15</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Michael E. Jones</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <u>6/15/70</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE <u>6-29-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>700</u>		24D. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>				25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

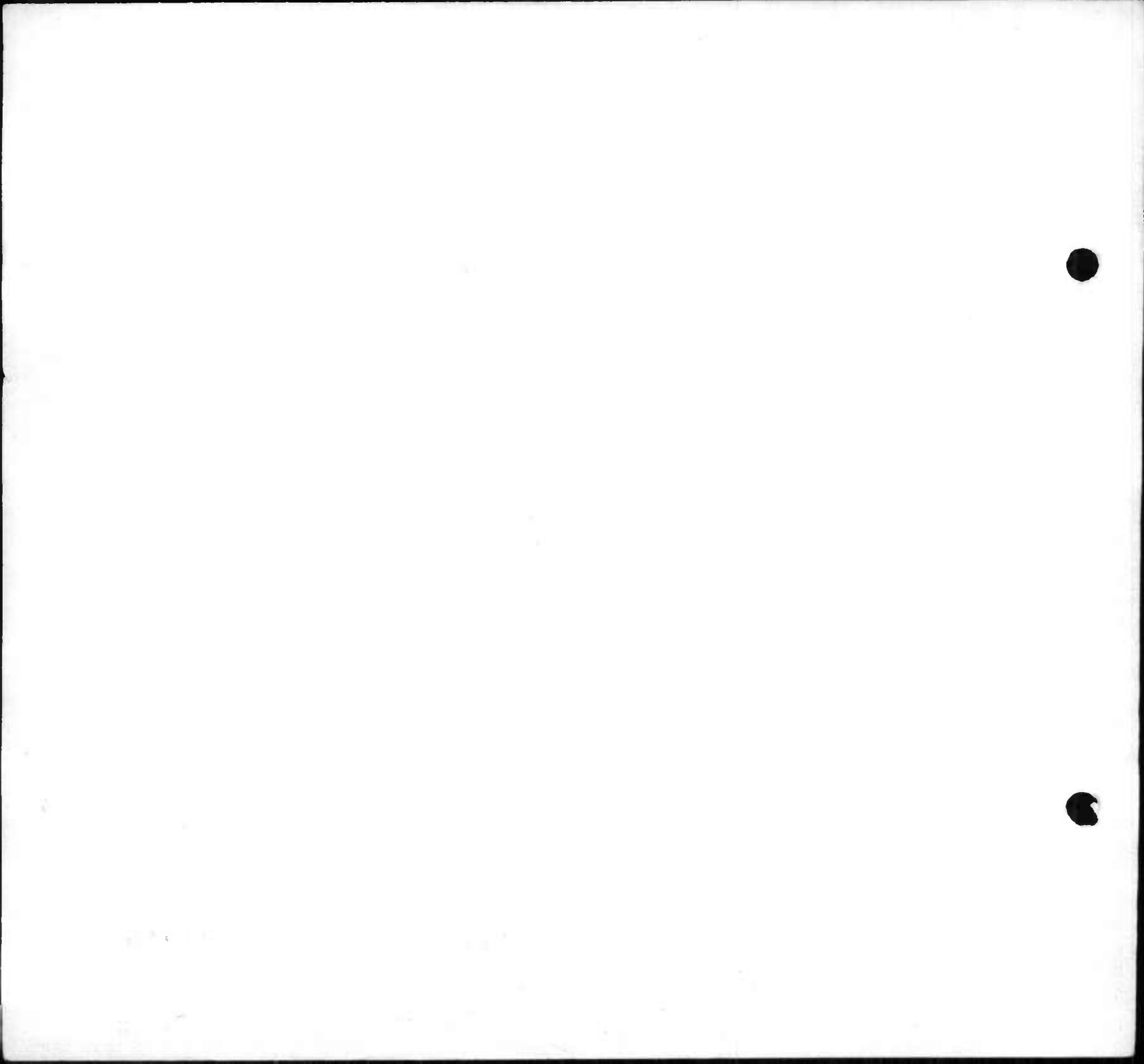
<div style="display: flex; justify-content: space-between;"> R-300 70 6628 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <u>70 6628</u>	
BIRTH NO. <u> </u>		2. DATE AND HOUR OF DEATH <u>6/23/70 - 5:30 AM</u>	
1. NAME OF DECEASED (Type or Print) <u>Lucille Reed</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Montebello State Hosp.</u>		C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>May 1904</u>		9. AGE (In years last birthday) <u>66</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10B. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Albert Brown</u>		14. MOTHER'S MAIDEN NAME <u>Nora Brown (maiden name with)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>None (hospital record)</u>		ADDRESS <u> </u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY Embolus</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u> </u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u> </u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u> </u> (C) <u> </u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>NEUROSYPHILIS</u> <u>OSTEOMYELITIS OF FEMUR</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u> </u>	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u> </u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u> </u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u> </u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u> </u>	
22. I certify that (I) (this hospital) attended the deceased from <u>19 6-23</u> to <u>19 70</u> that (I) (we) last saw the deceased alive on <u>6-23</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>F. Stuart, M.D.</u>		23B. DATE SIGNED <u>6/23/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>F. Stuart</u>		23D. ADDRESS <u> </u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>6-24-70</u>		24B. DATE <u>6-24-70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>		24D. LOCATION (City, town, or county) <u> </u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>	
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHO</u>		ADDRESS <u> </u>	

Unable to get correct address coded
to last block of N. Caroline St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

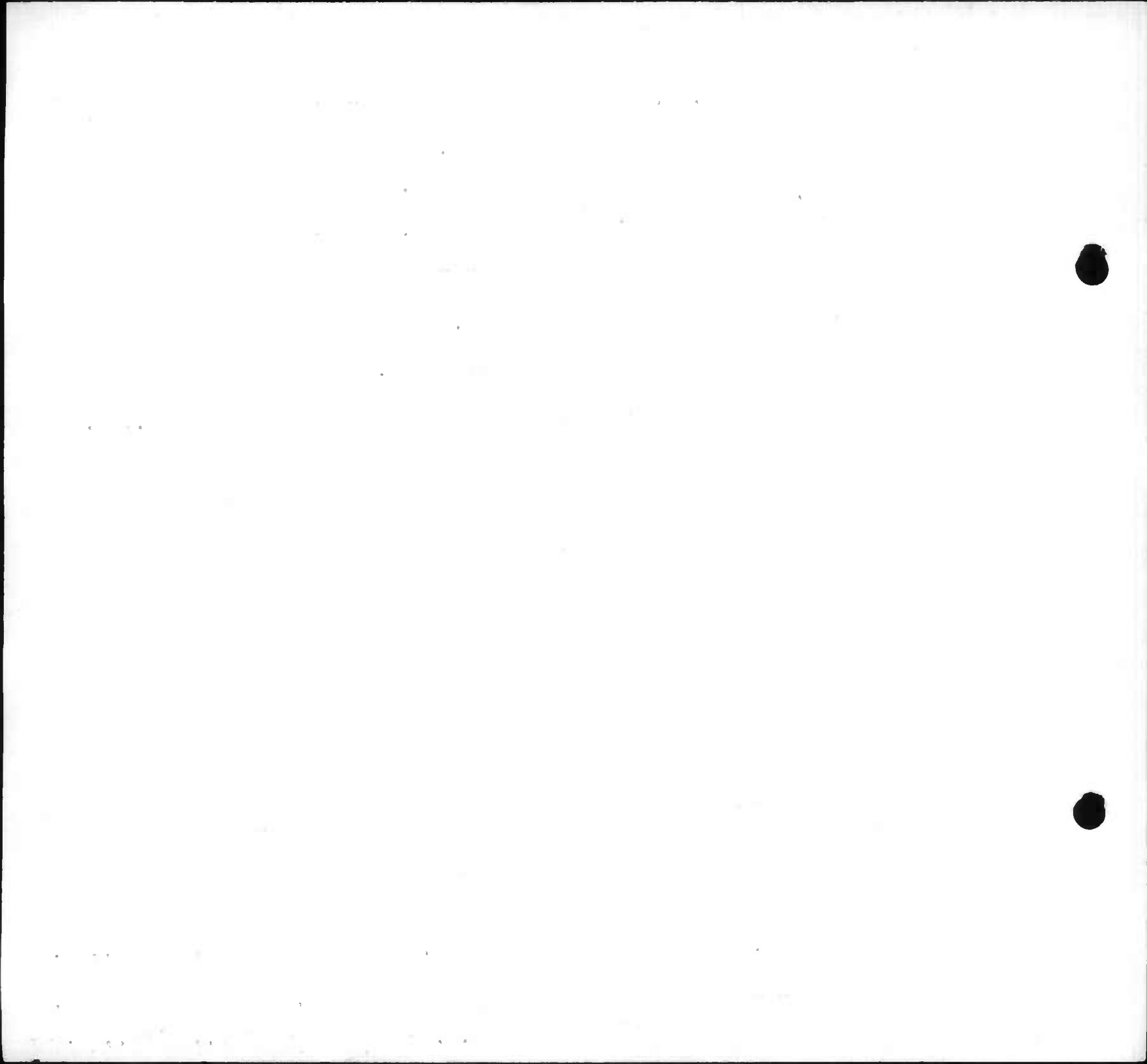
D-200 70 6629		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X	70 6629	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
		Diggs Maurice Clinton		6/20/70		445 AM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md. Frederick		6011
University Hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?
				Frederick		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
				E. STREET AND NUMBER		
				20 W. 6th St		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
M.	C	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8/13/18	51		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Arthur Diggs		Daisy Holland				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. 394.01		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cardiac failure		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:		B & H D. Mitral insuff. & Aortic insuff.		
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:		post mitral valvuloplasty		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
6/19/70		Mitral insufficiency		Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 6/14/70 to 6/20/70 that (I) (we) last saw the deceased alive on 6/20/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE		23B. DATE SIGNED				
J. M. Joautequy		6/20/70				
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS				
J. M. Joautequy		University Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
		6-29-70				
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS
JUL 1 1970		Robert E. Taylor, M.D.		MORTUARY SERVICE - BCHD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

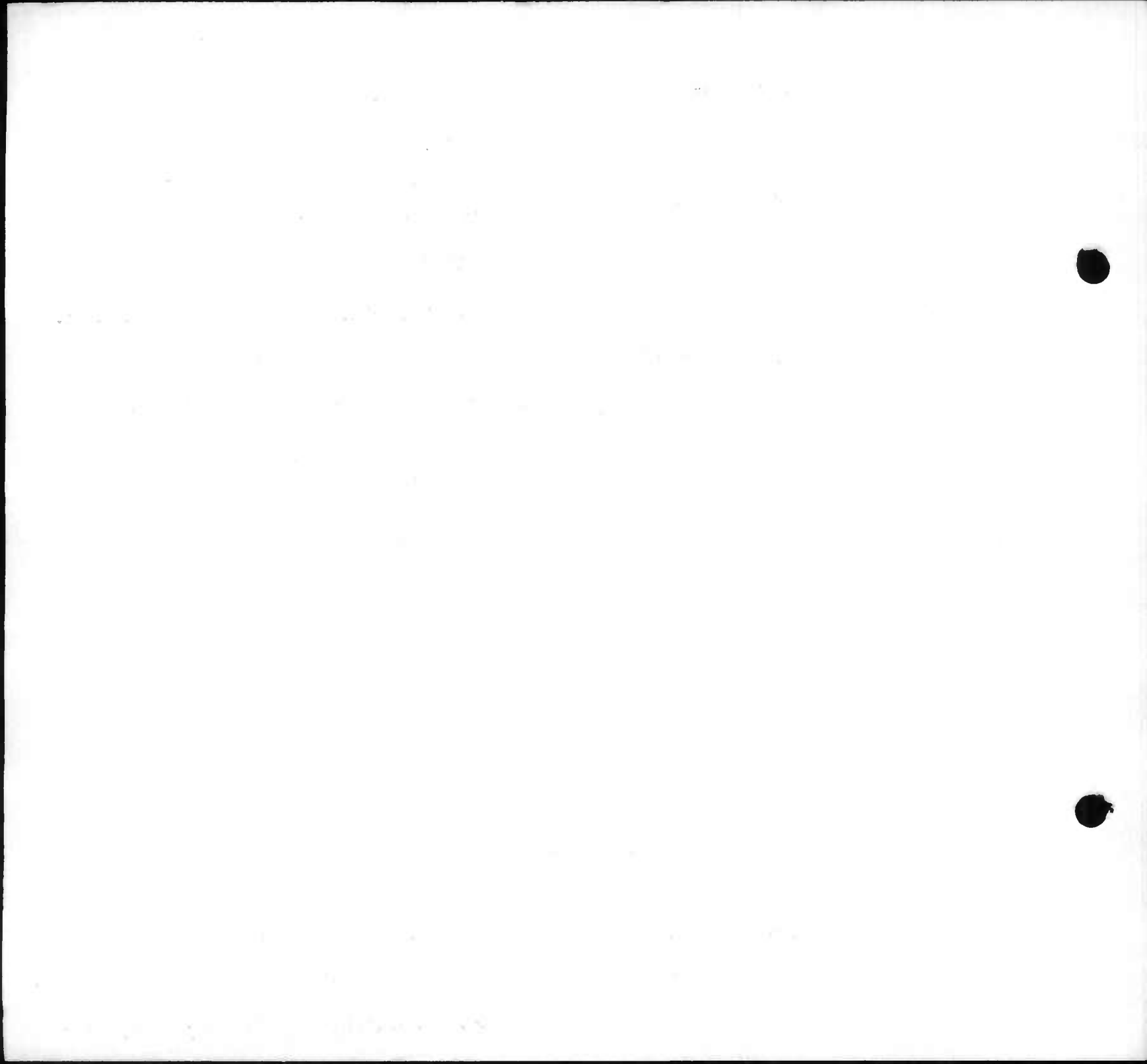
W-316		70 6630		BALTIMORE CITY HEALTH DEPARTMENT		70 6630	
CERTIFICATE OF DEATH				REG. NO. _____			
1. NAME OF DECEASED (Type or Print) Zillah T. L. Whiteford				2. DATE AND HOUR OF DEATH 6-30-70 12.15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 100 W. Cold Spring Lane Wynwood Towers Apts. 807				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2711			
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-4-1887	
9. AGE (In years last birthday) 83		10. UNDER 1 Yr. Months: _____ Days: _____		11. UNDER 24 Hrs. Hours: _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper				10B. KIND OF BUSINESS OR INDUSTRY Office			
13. FATHER'S NAME John Solomon Clayton				14. MOTHER'S MAIDEN NAME Rachel C. Newsome			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-14-5610		17. INFORMANT Alice Papen		ADDRESS Balto., Md.	
18. CAUSE OF DEATH 412.31 + 153.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antero-sclerotic Heart Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Primary Carcinoma of Colon with Metastasis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 4 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Generalized Antero-sclerotic							
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug 28 19 67 to June 30 19 70 that (I) (you) last saw the deceased alive on June 29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Earl L. Chambers				23B. DATE SIGNED 6/30/70			
23C. PHYSICIAN'S NAME (Type) Earl L. Chambers MD				23D. ADDRESS 100 W. Cold Spring Lane, Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-70		24C. NAME OF CEMETERY or CREMATORY Western		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.S.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co., Balto., Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

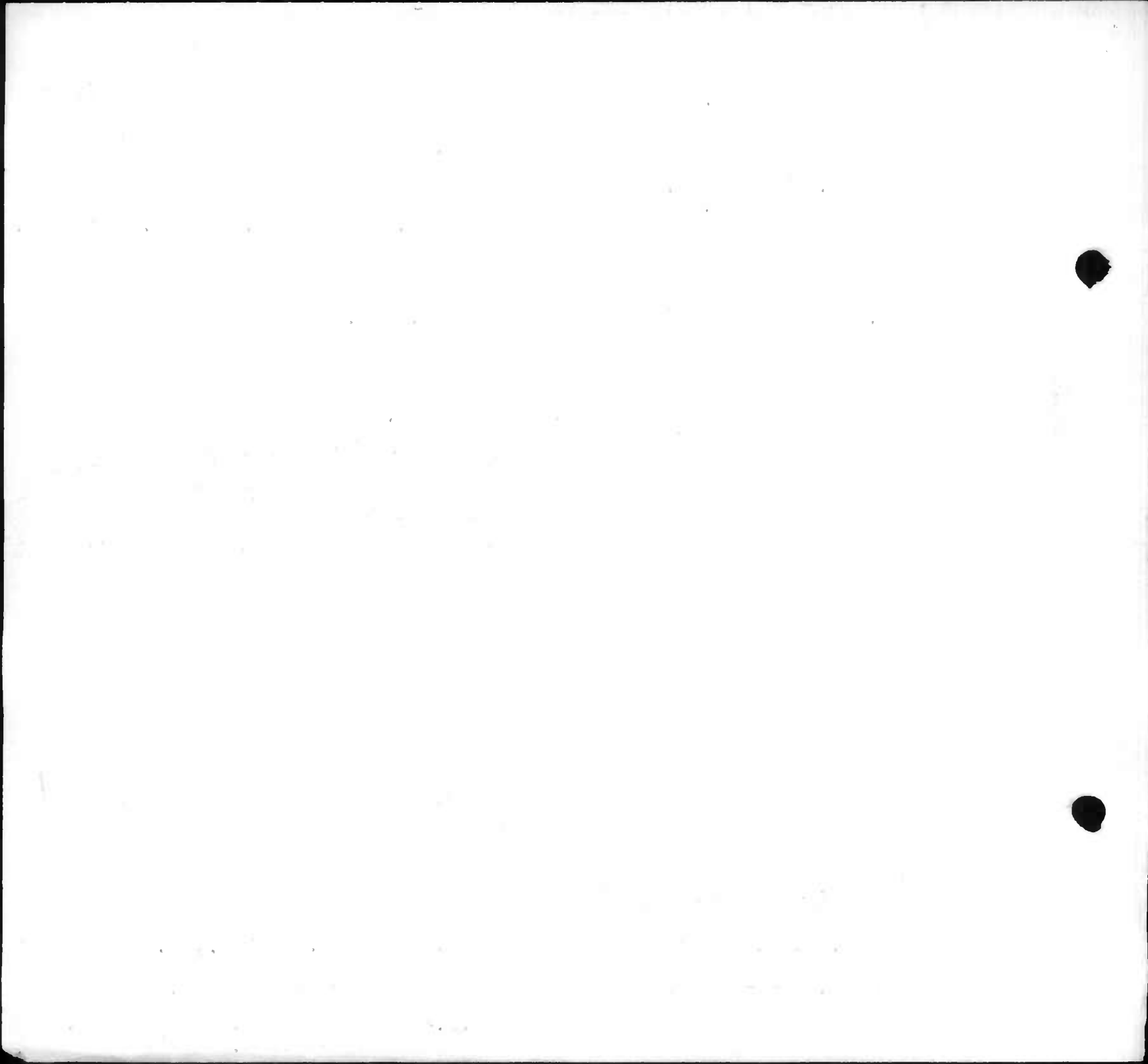
BIRTH NO. 8-363 70 6631		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6631	
1. NAME OF DECEASED (Type or Print) Mary Ross Stewart			2. DATE AND HOUR OF DEATH June 27, 1970 1 10³⁰ A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 416 Woodlawn Road			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2714		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 416 Woodlawn Road		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-1883	9. AGE (in years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Clarion, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME Dr. Frank Ross			14. MOTHER'S MAIDEN NAME Sarah Markillie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-4772B	17. INFORMANT Miss Mary Blanche Stewart		ADDRESS Same
18. 412-31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF: (B) Generalized Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerotic heart disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pulmonary emphysema & Bronchitis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 27 19 70 to 1970 and that (I) (we) last saw the deceased alive on June 27 19 70 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Walter B. Buck			23B. DATE SIGNED 6/29/70		
23C. PHYSICIAN'S NAME (Type) Dr. Walter B. Buck			23D. ADDRESS 18 E. Eager Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 6-30-70	24C. NAME of CEMETERY or CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 6632	
P-000 70 6632					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Philip L. Poe				2. DATE AND HOUR OF DEATH June 26, 1970 2:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1201	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3908 N. Charles St. Warrington Apts. 9 D				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3908 N. Charles St. Balto. 21218, Md.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1879	9. AGE (In years last birthday) 91	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exec. Broker		10B. KIND OF BUSINESS OR INDUSTRY Railroad-Stocks		11. BIRTHPLACE (State or foreign country) Balto., Md.	
13. FATHER'S NAME Neilson Poe				12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-14-5285	
17. INFORMANT Grace E. Poe				ADDRESS Same	
18. 4/2/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Sudden death cardiac arrhythmia rupture major artery (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Generalized arteriosclerosis, including coronary arteries (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instantaneous many years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 19 6/26/70 19 3/23/70 19 3/23/70 and that (I) (we) lost saw the deceased alive on 3/23/70 19 3/23/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE W. B. Daniels, Jr. M.D.				23B. DATE SIGNED 6/26/70	
23C. PHYSICIAN'S NAME (Type) Dr. W. B. Daniels				23D. ADDRESS 11 E. Chase St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Rem.		24B. DATE 7-1-70		24C. NAME OF CEMETERY or CREMATORY Laurel Hill	
24D. LOCATION (City, town, or county) (State) Philadelphia, Pa.					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR J. B. F. [illegible]		25C. FUNERAL DIRECTOR H. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



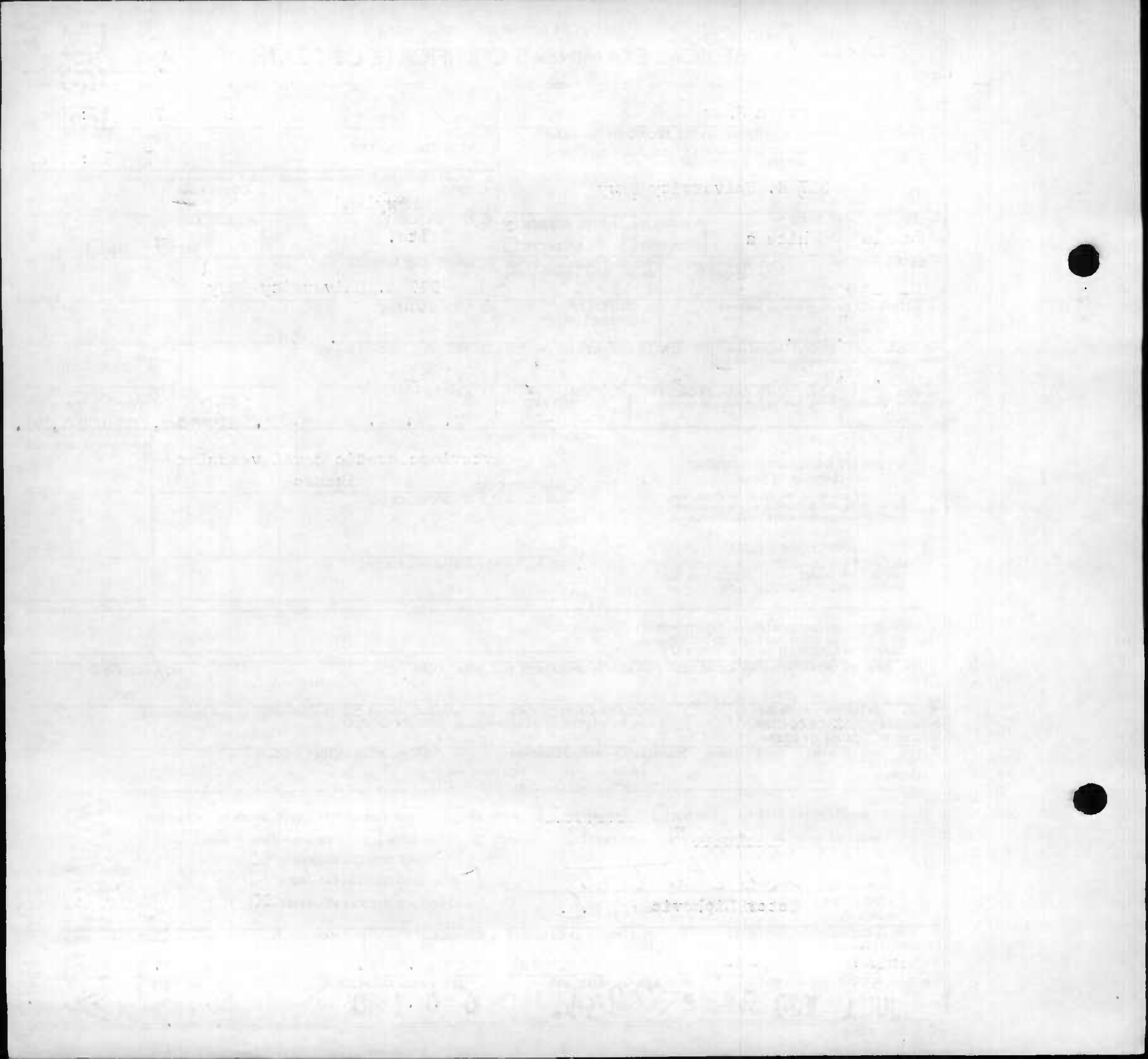
S-000 70

6633
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6633

BIRTH NO.

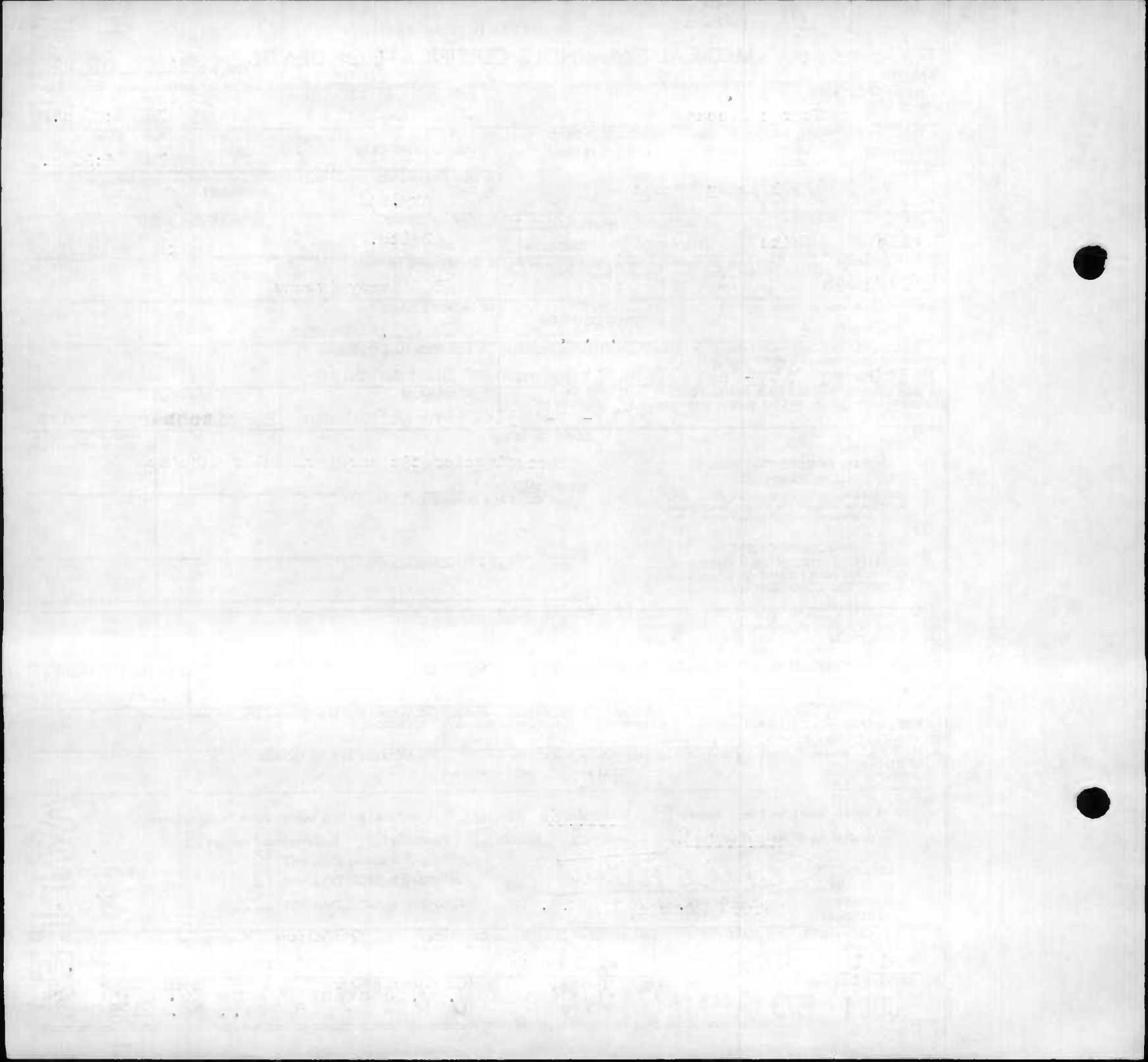
1. NAME OF DECEASED (Type or Print) Marian Shaw				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 6 28 70 10:20 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 317 E. University Pkwy				3. DATE PRONOUNCED DEAD Month Day Year 6 28 70 10:20 a.m.			
6. SEX female				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5-9-1900				10. AGE (In years lost birthday) 70		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William E. Shaw			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Florist				15. MOTHER'S MAIDEN NAME Ella Lynn			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				17. SOCIAL SECURITY NO. 218-10-4545		18. INFORMANT Mr. W. B. Shaw, Jr.	
19. 4/2/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 7-1-70				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7-1-70				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 6/29/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-1-70			
24C. NAME OF CEMETERY or CREMATORY Piney Creek Presby. Cem.				24D. LOCATION (City, town, or county) (State) Taneytown, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			
25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.				ADDRESS 4905 York Rd. Baltimore, Md. 21212			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6634

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>George Greene</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 28 70 6:35 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>5303 Ready Avenue</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 28 70 6:35 a. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2710</u>	
6. SEX <u>male</u>	7. RACE <u>White</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>4/11/1896</u>		10. AGE (In years last birthday) <u>74</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baltimore City-Dept Of Sanitation</u>		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <u>Sam G. Greene</u>	
15. MOTHER'S MAIDEN NAME <u>Louisa Rapp</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWI</u>		17. SOCIAL SECURITY NO. <u>717-07-8931</u>	
18. INFORMANT <u>Jerry Mathison</u>		18. ADDRESS <u>2 Stitchberry Court</u>		19. CAUSE OF DEATH <u>Arteriosclerotic cardiovascular disease</u>	
20A. DATE OF OPERATION <u>7/12/70</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>no</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>7/1/70</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Peter Lipkovic</u> M.D. EXAMINER'S NAME (Type) <u>Peter Lipkovic, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/29/70</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore</u>	
24D. LOCATION (City, town, or county) <u>Baltimore</u>		24E. LOCATION (State) <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>	
25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>		25C. FUNERAL DIRECTOR <u>B. W. Jenkins & Sons Co.</u>		25D. ADDRESS <u>4905 York Rd Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6635</u>	
C-230		70 6635			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ALEXANDER CIUCHTA</u>		2. DATE AND HOUR OF DEATH <u>6/20/70</u> <u>12:55 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>103</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>35 CHURCH HOME AND HOSPITAL</u> <u>BALTIMORE, MD.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M.</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Steel worker</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>2-29-94</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		9. AGE (In years last birthday) <u>76</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-3669</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
		17. INFORMANT <u>MR. MILTON S. CIUCHTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>717 S. MONTFORD AVE</u>	
18. <u>25019 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>One hour.</u> <u>5 hours.</u> <u>7 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Pulmonary Edema</u>				<u>One hour.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>1</u> (this hospital) attended the deceased from <u>June 19 1970</u> to <u>June 20 1970</u> that <u>1</u> (we) last saw the deceased alive on <u>June 20 1970</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>1</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Raymond L. Kaczorowski</u>		23B. DATE SIGNED <u>6/20/70</u>		23C. PHYSICIAN'S NAME (Type) <u>ROLANDO X. MENDRANA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>6/23/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEM.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>RAYMOND L. KACZOROWSKI</u>	
				ADDRESS <u>2525 FLEET ST.</u>	

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6636

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

John Easter

2. DATE OF DEATH

Known ☐ Estimated ☐

Month Day Year

6 28 70

Hour

3:05 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 South Balto. Gen. Hosp.

3. DATE PRONOUNCED DEAD

Month Day Year

6 28 70

Hour

3:05 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

2303

6. SEX

male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

2-3-08

10. AGE (In years last birthday)

62

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

13 W. Barney

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SELU. STA. OP.

14B. KIND OF BUSINESS OR INDUSTRY

ESSO

15. MOTHER'S MAIDEN NAME

CALLIE BAUMANN

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

FAM. & - SAME

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☒ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED 6/29/70

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

7-4-70

24C. NAME OF CEMETERY or CREMATORY

GLEN HAGEN

24D. LOCATION (City, town, or county)

BALTIMORE

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1970

25B. NAME OF REGISTRAR

Robert E. [illegible]

25C. FUNERAL DIRECTOR

[illegible] - 130 E. Fort Ave

ADDRESS

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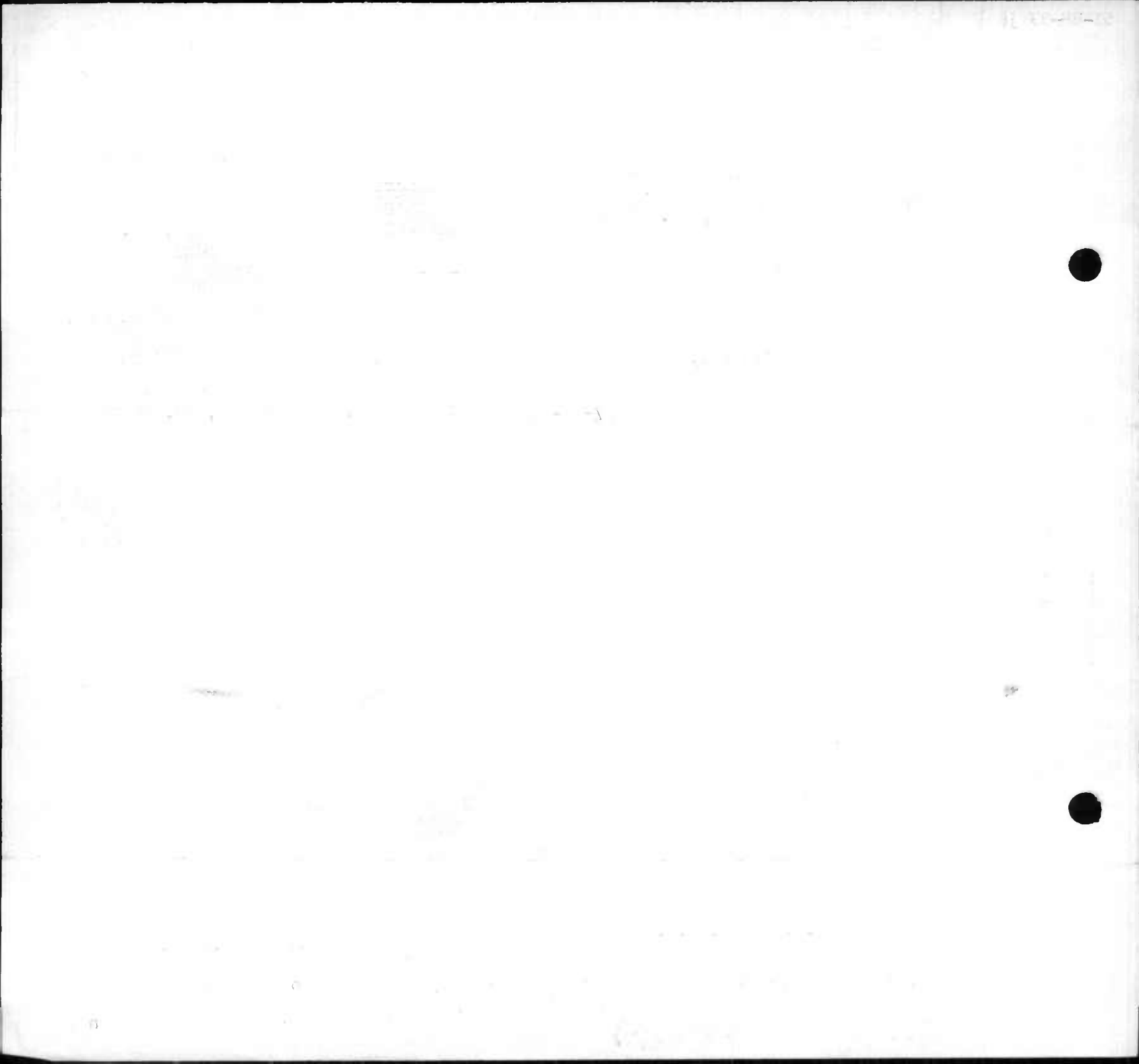
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
L-535		70 6637		X		70 6637	
1. NAME OF DECEASED (Type or Print) Catherine Lindner				2. DATE AND HOUR OF DEATH 6/28/70 1 9 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3/ Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. 21224				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balto. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1504 Delvale Ave., Baltimore, Md. 21222			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-84	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Rittmetey				14. MOTHER'S MAIDEN NAME Dorothea Schick			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 218-62-4249		17. INFORMANT BCH Records: 4940 Eastern Avenue Baltimore, Md. 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH nine mos years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). bact cell carcinoma of neck						2 yrs	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 2/4 1969 to 6/28 1970 that (1) (we) last saw the deceased alive on 6/28 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J.R. Neefe, M.D.				23B. DATE SIGNED 6/28/70			
23C. PHYSICIAN'S NAME (Type) J.R. Neefe, M.D.				23D. ADDRESS Baltimore City Hospital 4940 Eastern Ave., Balto., Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-70		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR WALTER DABROWSKI		ADDRESS 1005 Dundalk Avenue	



B-500

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6638

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70

6638

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RUSSELL BEAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year June 23, 1970 Hour 5:15 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Ellicott City	
9. DATE OF BIRTH 4-22-1907		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas BEAN		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C.A.	
15. MOTHER'S MAIDEN NAME MARATHA NESSEBROOKE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 213-03-2067		18. INFORMANT LUCILLE BEAN ADDRESS 8298 MAIN ST. ELlicott City, Md.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 6/24/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-25-70	
24C. NAME OF CEMETERY or CREMATORY Good Shepherd		24D. LOCATION (City, town, or county) (State) Ellicott City Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Wigington & Slack		ADDRESS Ellicott City, Md.	

323

MEDICAL HISTORY REPORT OF D. J. H.

DATE: 10-10-1961

BY: DR. J. H. H.

X

4-25-1961

Thomas Green

Virginia

Specialty: General Medicine

D.O.

General Exam: Good

no

DATE: 10-10-1961

DR. J. H. H.

Signature

General Exam: Good

Specialty: General Medicine

G-451

70

6639

BALTIMORE CITY HEALTH DEPARTMENT

70

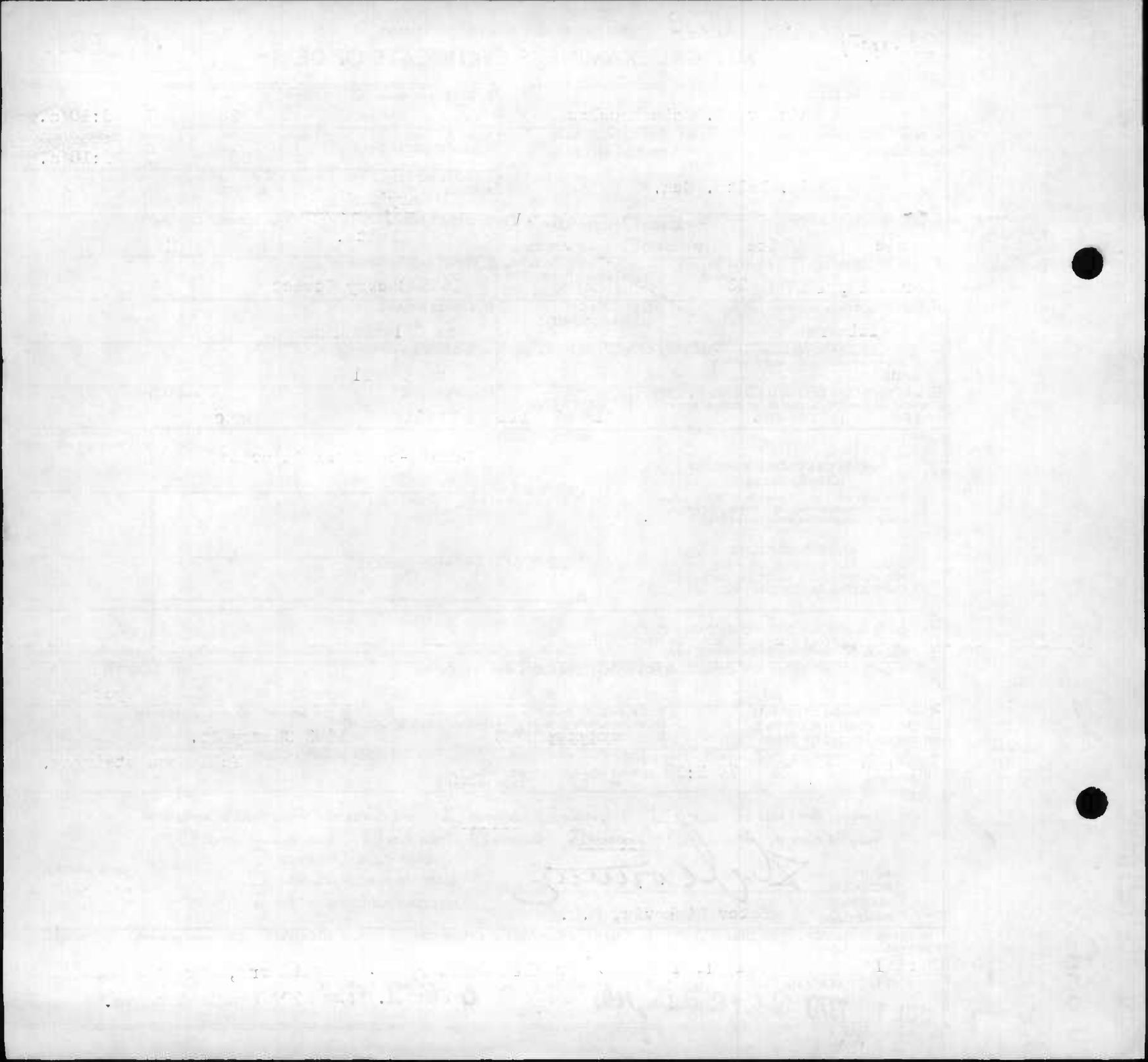
6639

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

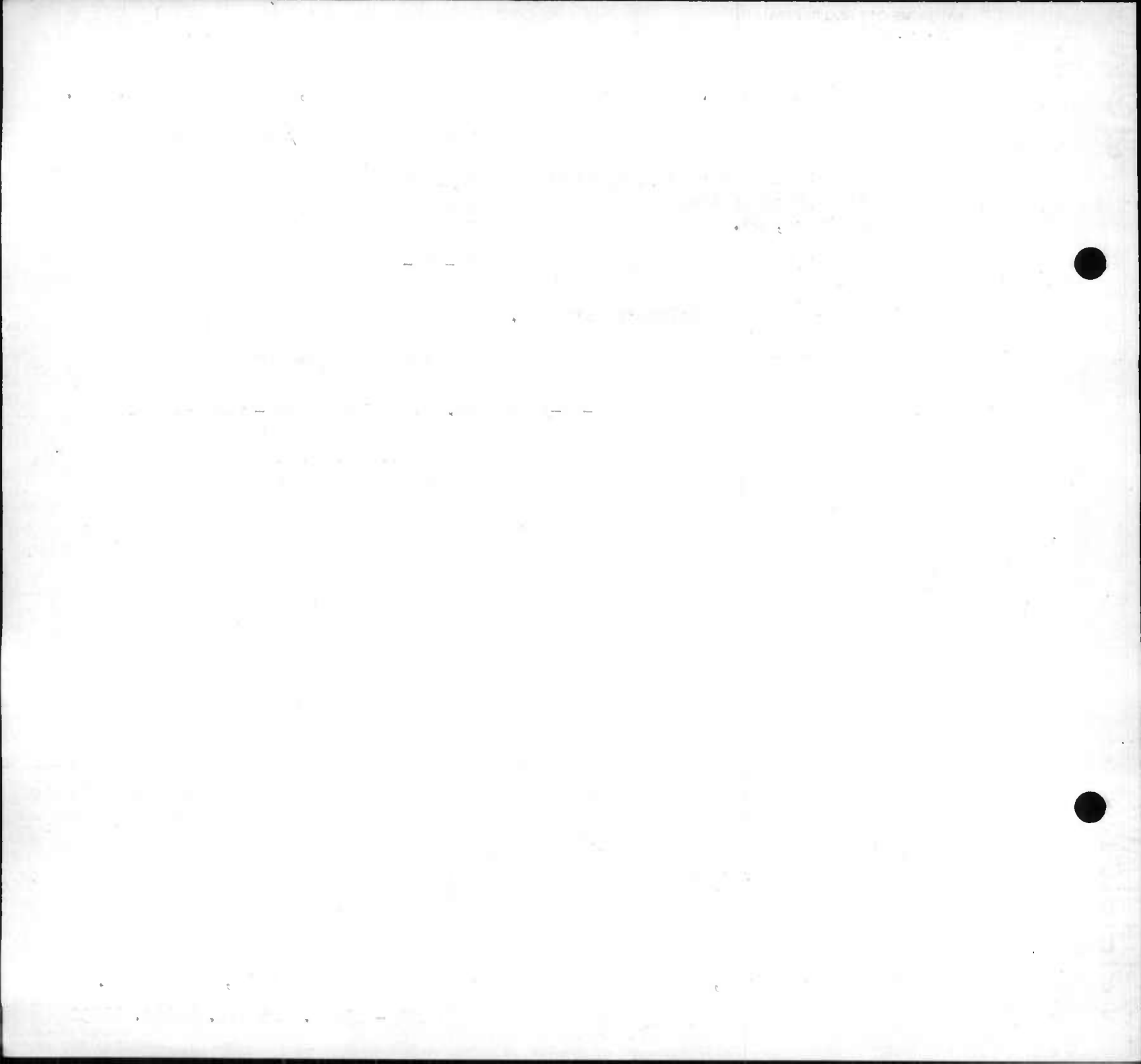
1. NAME OF DECEASED (Type or Print) Richard P. Gelumbauskas				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 28 70 5:10 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 So. Balto. Gen.				3. DATE PRONOUNCED DEAD Month Day Year Hour 6 28 70 5:10 a.m.			
6. SEX male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH March 13, 1947				10. AGE (in years lost birthday) 23		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Leo Gelumbauskas			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME Pearl Wall				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Present			
17. SOCIAL SECURITY NO. 219 52 9111				18. INFORMANT Family			
19. CAUSE OF DEATH E8801X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Craneo-cerebral injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) X HOME			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1603 Cherry St. 2505				22D. TIME OF INJURY (APPROX.) 6 28 70 3:30 a			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Fell down stairway.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/29/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 1, 1970		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John H. Mann		ADDRESS 4200 Pennington Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6640	
M-320 70 6640 CERTIFICATE OF DEATH		1 BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Clifton A. Matthews			2. DATE AND HOUR OF DEATH June 28, 1970 1:40 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 House in the Pines Nursing Home 2525 Belvedere Avenue Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY N 7 A C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1313 James Street		
5. SEX Male 6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 - 9 - 1890 9. AGE (In years lost birthday) 80 If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottle Maker		10B. KIND OF BUSINESS OR INDUSTRY Columbia Glass Co.		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Matthews			14. MOTHER'S MAIDEN NAME Sarah (Walters)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-3704		17. INFORMANT Mrs. Catherine Brack - name as # 1 ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 162.1 BRONCHITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH BRONCHITIS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C A of Larynx (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 5 yrs.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JUNE 22 1970 to JUNE 28 1970 , that (I) last saw the deceased alive on JUNE 26 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Alan B. Cohen				23B. DATE SIGNED June 28, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 1, 1970		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR McCully - 130 E. Fort Ave. Balto. 21230 ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P. 455

70 6641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

70 6641

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) Lilly Plemmons

2. DATE AND HOUR OF DEATH
6/27/70 2:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
31 BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☐ NO ☒
E. STREET AND NUMBER 247 St. Helena Avenue

5. SEX Female 6. RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 8-15-01 9. AGE (In years last birthday) 68 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Arthur

14. MOTHER'S MAIDEN NAME Cora Miller

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 578-24-4869

17. INFORMANT ADDRESS BCH:Records 4940 Eastern Avenue Baltimore, Maryland 21224

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Asphyxia arrest
(B) DUE TO, OR AS A CONSEQUENCE OF: Septicemia
(C) DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min
3 days
5 days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION 6
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) NO
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

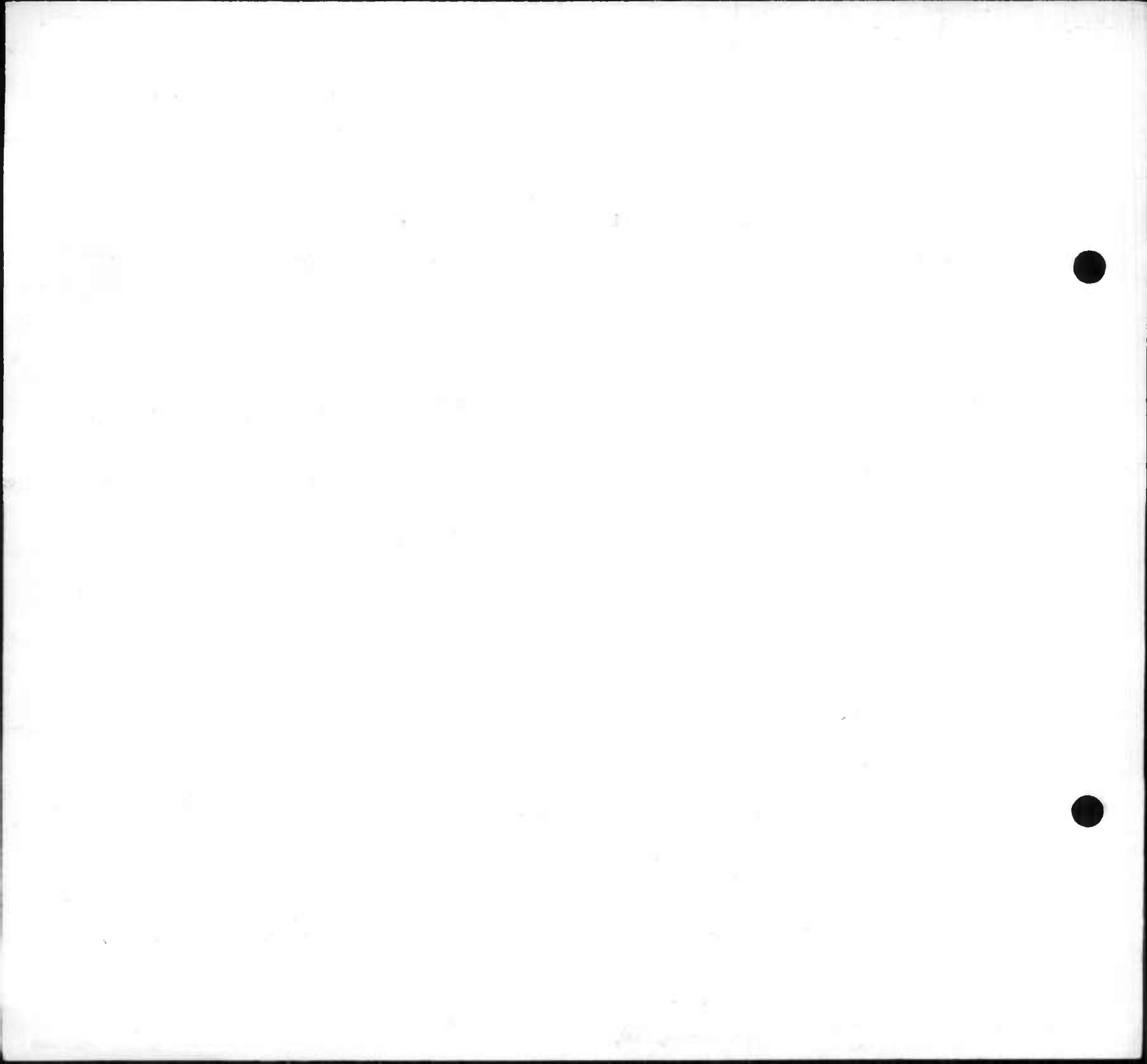
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)
21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐
21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 6-23 19 70 to 6-27 19 70 that (1) (we) last saw the deceased alive on 6-27 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE John R. Brechtel
23B. DATE SIGNED 6-27-70
23C. PHYSICIAN'S NAME (Type) John R. Brechtel
23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Balto., Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify) Burial
24B. DATE 6/30/70
24C. NAME OF CEMETERY OR CREMATORY Zion Hill Cemetery
24D. LOCATION (City, town, or county) (State) Belair, Md.

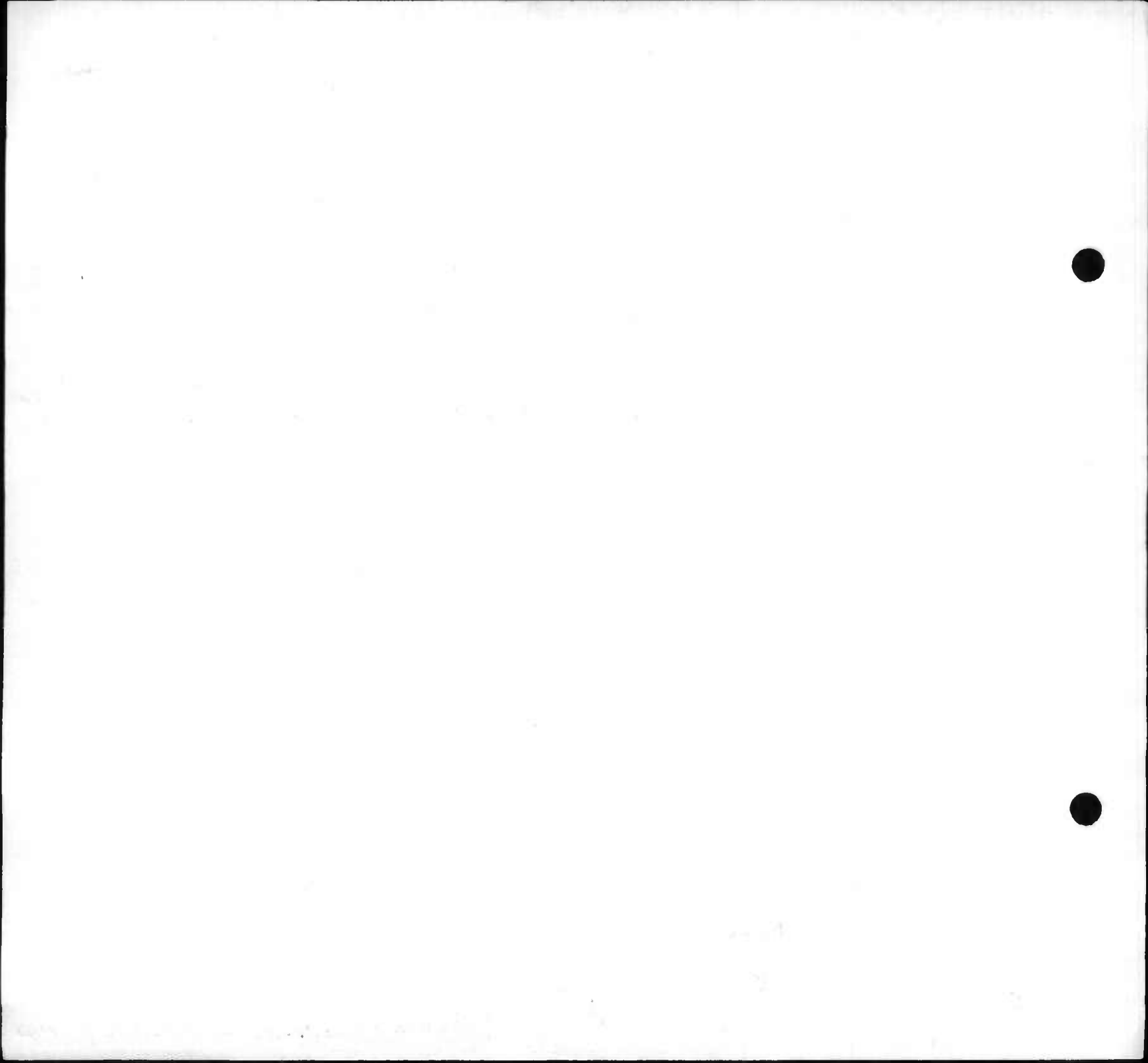
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970
25B. NAME OF REGISTRAR Robert E. Taylor
25C. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

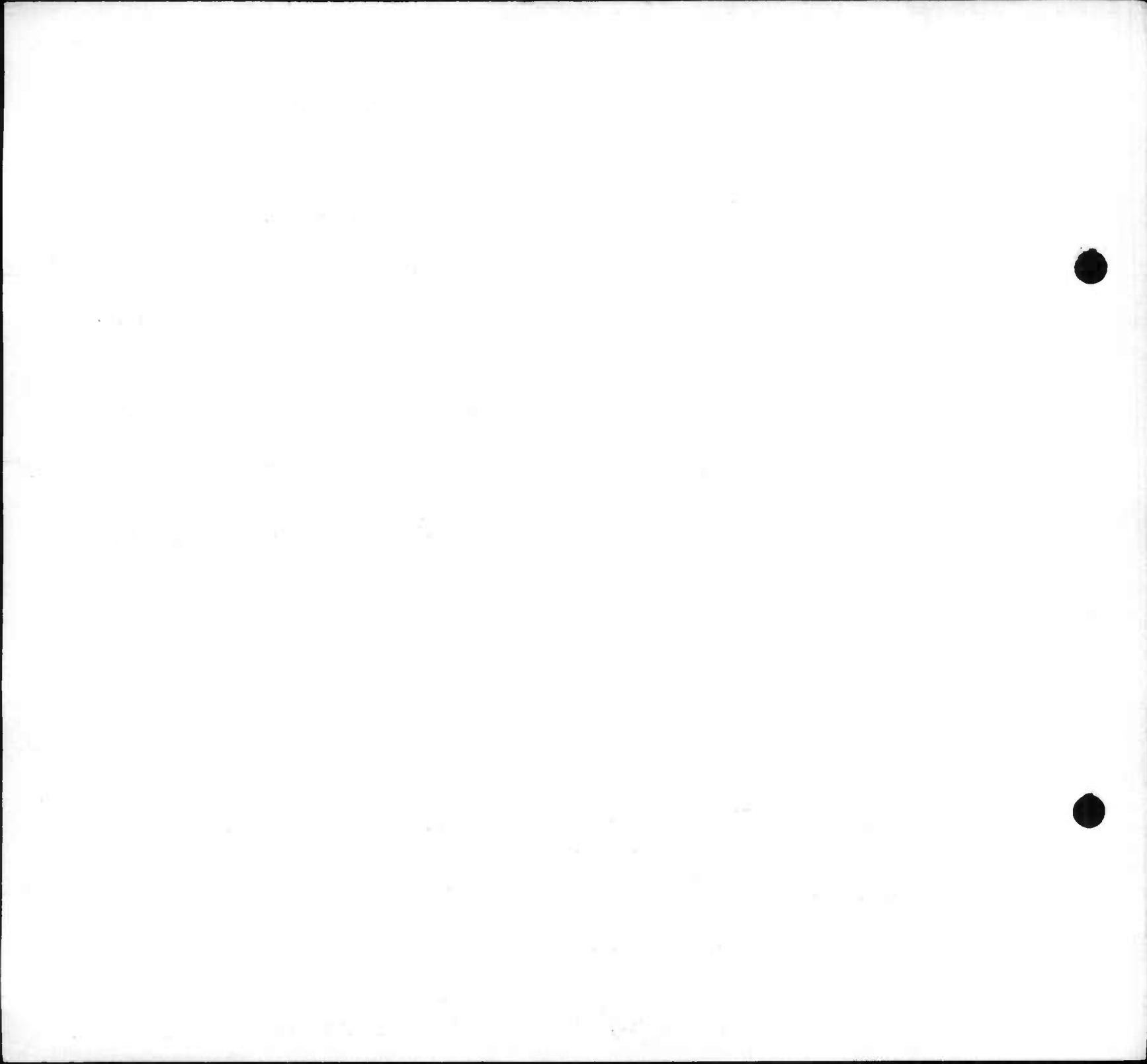
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-536		70 6642		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 6642	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
HARLEY FLOYD POYNTER				JUNE 27 1970 2. P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY			
CHURCH HOME AND HOSPITAL				MD.		DUNDALK.		5300	
BALTIMORE, MD.				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER					
				7721, MEATH ROAD.					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9/8/17		52			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CONSTRUCTION WORKER				STONE		MINNESOTA		AMERICA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
FLOYD POYNTER				ALICE GALE					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				476-10-9926		MRS FLORENCE POYNTER - 7721 MEATH RD			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE					
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)				Intracerebral hematoma					
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				chr. alcoholism					
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				Liver cirrhosis.					
				(C)					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
O									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from				6/27 19 70		to 6/27 19 70			
that (I) (we) last saw the deceased alive on				6/27 19 70		and that in (my) (our) opinion death occurred on the date			
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED			
A.E. Chauvalit, M.D.				DEGREE		6/27/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
A.E. CHAUVALIT, M.D.				DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
CREMATION		6/30/70		GREENMOUNT CEM.		BALTIMORE		MD	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JUL 1 1970		Robert F. Jackson, M.D.		VULTRICH FUNERAL HOME		DUNDALK MD			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

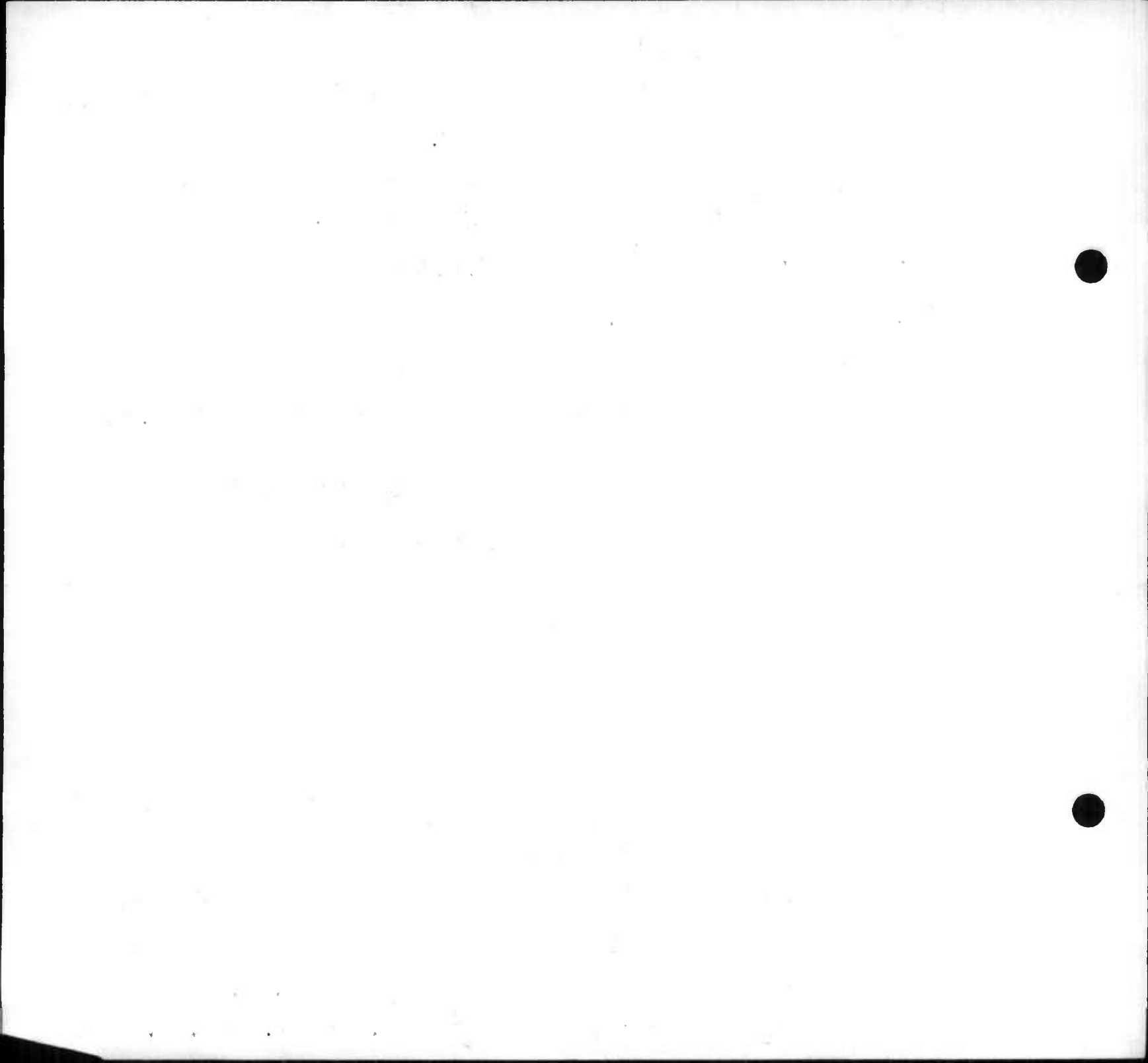
BIRTH NO. <u>B-650</u> <u>70</u> <u>6643</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>70</u> <u>6643</u>	
1. NAME OF DECEASED (Type or Print) <u>MARY ELIZABETH BROOM</u>		2. DATE AND HOUR OF DEATH <u>June 28, 1970</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2807 Brendon Ave.,</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>831</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>2807 Brendon Ave.</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1885</u>	9. AGE (in years last birthday) <u>85</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Walter</u>		14. MOTHER'S MAIDEN NAME <u>Frances White</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William J. Broom 2807 Brendon Ave.</u>	
18. <u>4/12/3</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Coronary Recompensation</u> (B) <u>Arteriosclerotic Coronary Heart Disease 8 years</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>January 20</u> 19 <u>54</u> to <u>June 28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>June 23</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Melvin F. Polek</u>		23B. DATE SIGNED <u>June 29, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Melvin F. Polek, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Memo. Gardens</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Ulrich Funeral Home, 4210 Belair Road.</u>	
24D. LOCATION (City, town, or county) <u>Towson, Md.</u>		24E. ADDRESS <u>3603 Belair Road</u>		24F. ADDRESS <u>Ulrich Funeral Home, 4210 Belair Road.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

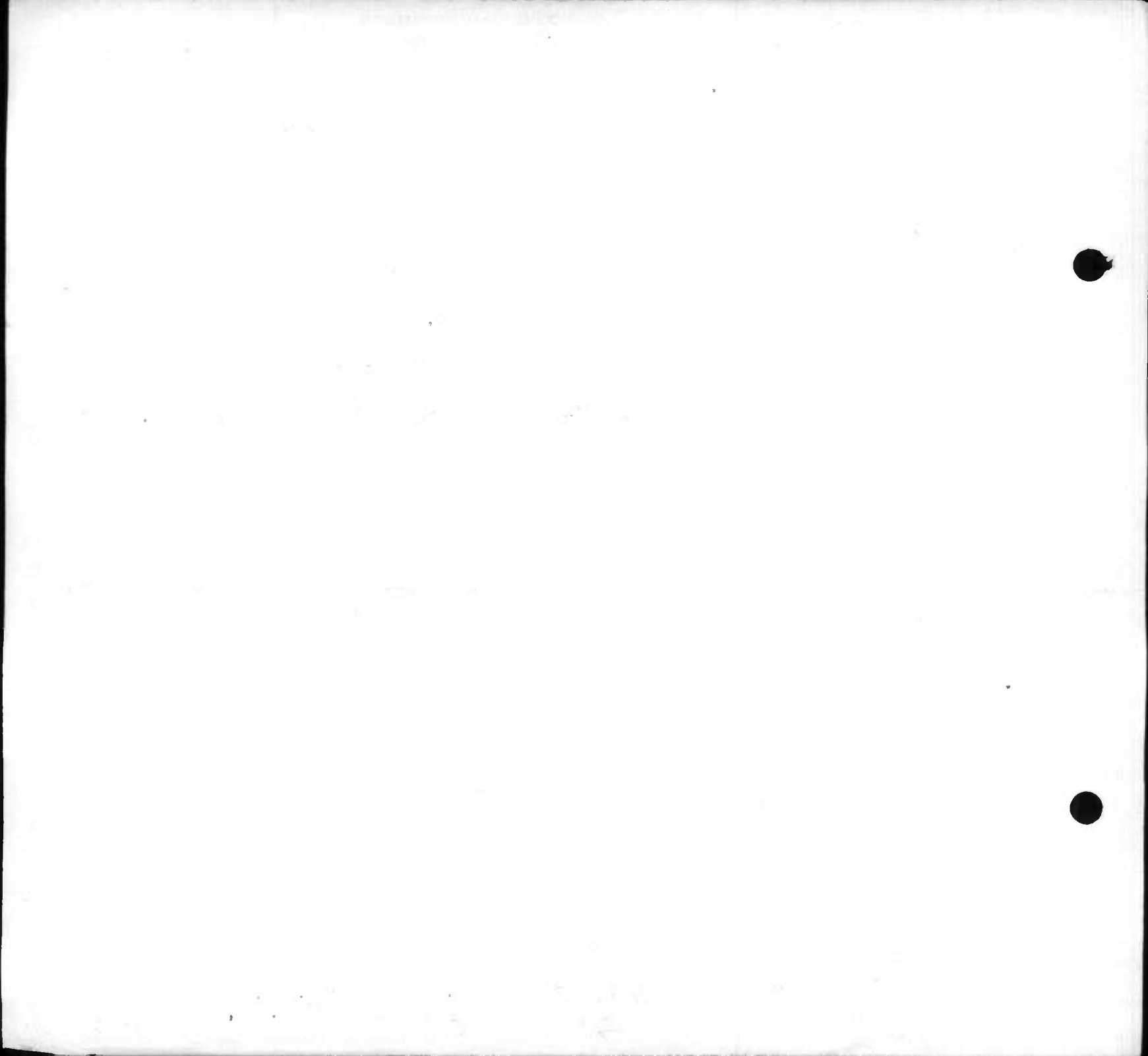
BALTIMORE CITY HEALTH DEPARTMENT				70 6644		REG. NO. 70 6644	
BIRTH NO. K-300				70 6644		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) James Milton Kidd				2. DATE AND HOUR OF DEATH 6/28/70 18:50a M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3102 Tyndale Road				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2731			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3102 Tyndale Rd.			
5. SEX M.	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/25/1902	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer		10B. KIND OF BUSINESS OR INDUSTRY Martin Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Kidd				14. MOTHER'S MAIDEN NAME Judith Eppl			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-9554		17. INFORMANT ADDRESS Mrs Matha L Kidd 3102 Tyndale Rd. 21214			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0				CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic C.V.D. DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>1956</u> to <u>June 28</u> 19 <u>70</u> that (I) (<u>we</u>) last saw the deceased alive on <u>May</u> 19 <u>70</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (<u>not</u>) view the body after death.							
23A. SIGNATURE J. Henry Haase M.D.				23B. DATE SIGNED 6/29/70		23C. PHYSICIAN'S NAME (Type) J. Henry Haase M.D.	
23D. ADDRESS 2526 S. Calverton Rd. Balto. Md.				23E. DEGREE M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-70		24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		25D. ADDRESS Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-650 70 6645		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6645
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH A. SCARANO		2. DATE AND HOUR OF DEATH 6-29-70 1:30 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO. CO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLOT 660 HOSPITAL		E. STREET AND NUMBER 1813 TAYLOR AVE.		
5. SEX Male	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1898	9. AGE (In years last birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.
13. FATHER'S NAME Angelo Scarano		14. MOTHER'S MAIDEN NAME Nicolina Senna		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-8393		17. INFORMANT Mrs Victoria Denest ADDRESS West Chester, Penna. 07111
18. 52191 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute BRONCHOPNEUMONIA 2 days (B) CHRONIC MALNUTRITION DUE TO, OR AS A CONSEQUENCE OF: LOWER CURRITISIS		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6/27 19 70 to 6/29 19 70 that (I) (we) last saw the deceased alive on 6/29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE M. A. ...		23B. DATE SIGNED 6/29/70		23C. PHYSICIAN'S NAME (Type) ...
23D. ADDRESS NORTH CHARLES HOSPITAL		23E. FUNDING DIRECTOR ...		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-2-70	24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem.	24D. LOCATION (City, town, or county) (State) Balto. Md.	25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR E. J. Ruck Inc. ADDRESS 5305 HANFORD RD.		



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T-520

70 6646

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6646

BIRTH NO.

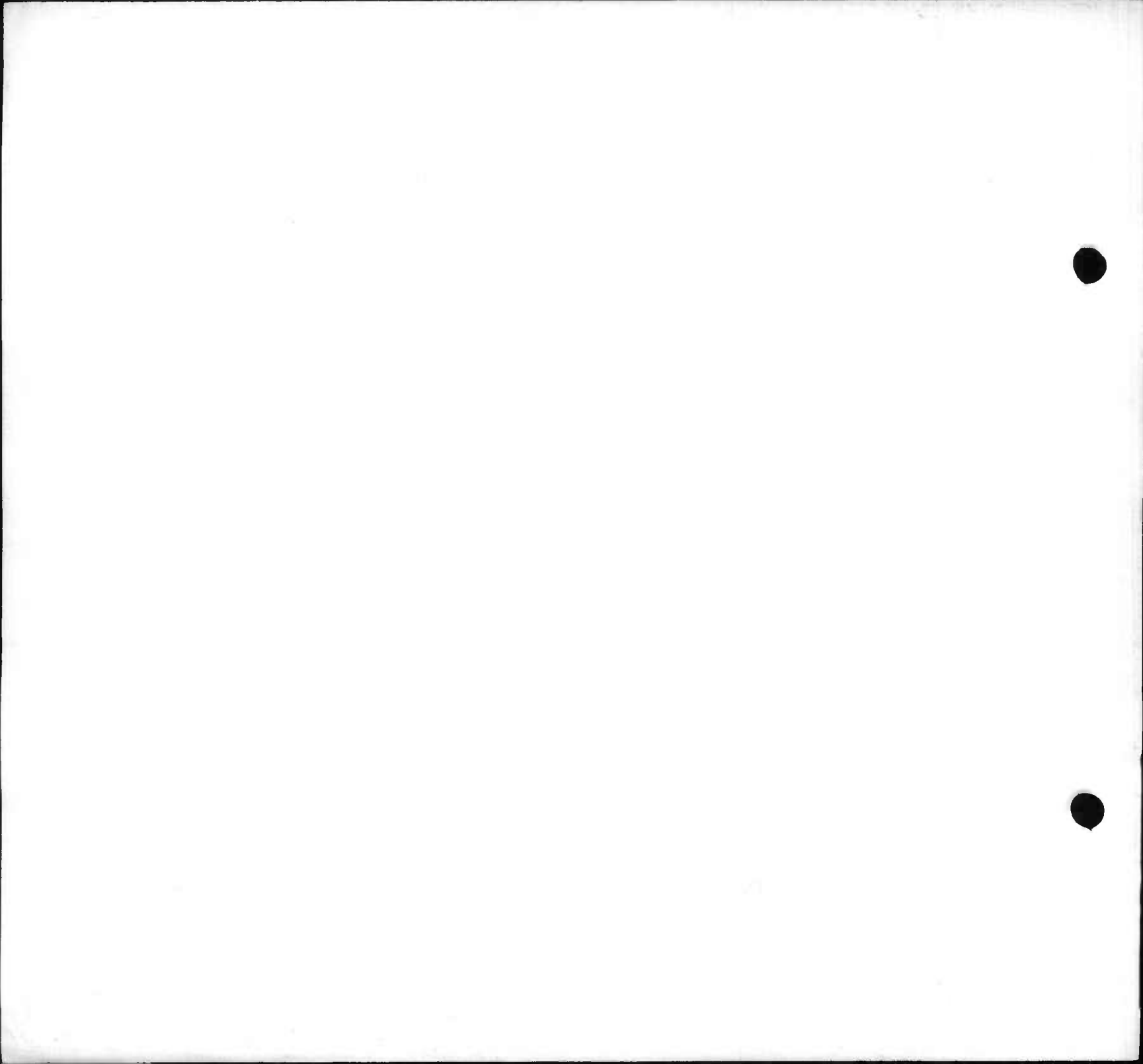
1. NAME OF DECEASED (Type or Print) James Thomas		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours		3. DATE PRONOUNCED DEAD Month 6 Day 29 Year 70		Hour 4:25		M. P.	
6. SEX male		7. RACE colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH NOV 22 1945		10. AGE (In years last birthday) 24		11. BIRTHPLACE (State or foreign country) GA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry L THOMAS		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		15. MOTHER'S MAIDEN NAME GEORGIA JAMES		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES	
17. SOCIAL SECURITY NO. 216 42688		18. INFORMANT GEORGIA THOMAS		19. CAUSE OF DEATH Gunshot wound of chest and abdomen		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 200 Blk. Parrish St.		1901	
22D. TIME OF INJURY (APPROX.) 6 27 70 3:05 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot during altercation			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/30/70	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy Chief Medical Examiner					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/70		24C. NAME OF CEMETERY or CREMATORY BALTO NATIONAL		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Robert E. Taylor		ADDRESS 638 N 9th St	

James M. Davis
Department of Health

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

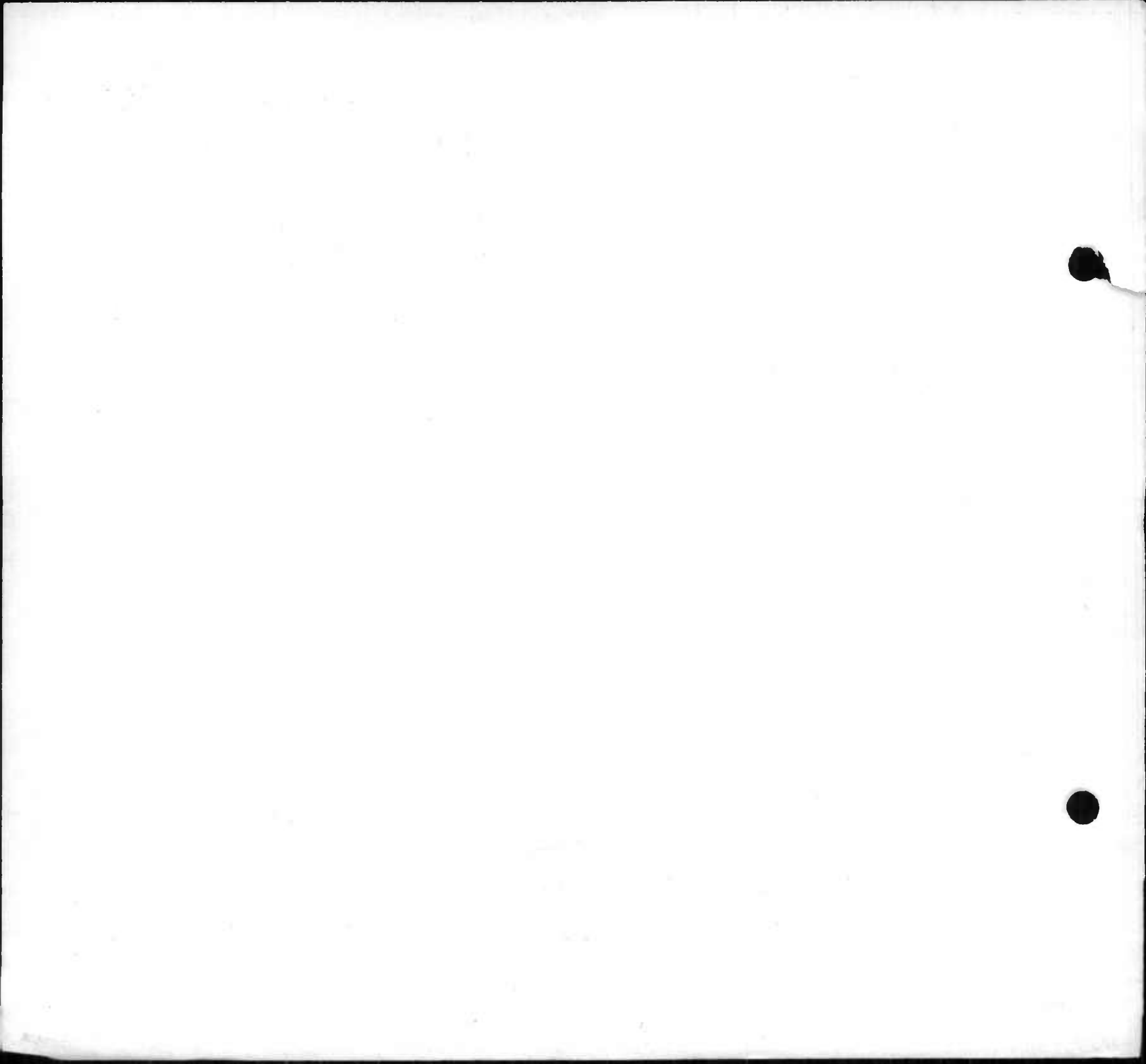
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 6647
B-260 70 6647 BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANCES G BAKER		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL 44		2. DATE AND HOUR OF DEATH 6/29/70 11:15 P. M. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1510 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3P 40 22 BOARMAN AVE		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06-08-37	9. AGE (In years last birthday) 33 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY R		
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME LEON JOHNSON		14. MOTHER'S MAIDEN NAME LESLIE WILSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ALVIN N. BAKER
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 282.91		CAUSE OF DEATH (A) IMMEDIATE CAUSE myocardial infarction hemolytic anemia DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6/23 19 70 to 6/29 19 70 that (I) (we) lost saw the deceased alive on 6/29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE DP. VAN KAMMEN MD		23B. DATE SIGNED 6/29 70		23C. PHYSICIAN'S NAME (Type) DP. VAN KAMMEN MD
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/70		
24C. NAME OF CEMETERY OR CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave		
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		
25C. FUNERAL DIRECTOR Joseph B. Locks		25D. ADDRESS 1304 N. Central Ave		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

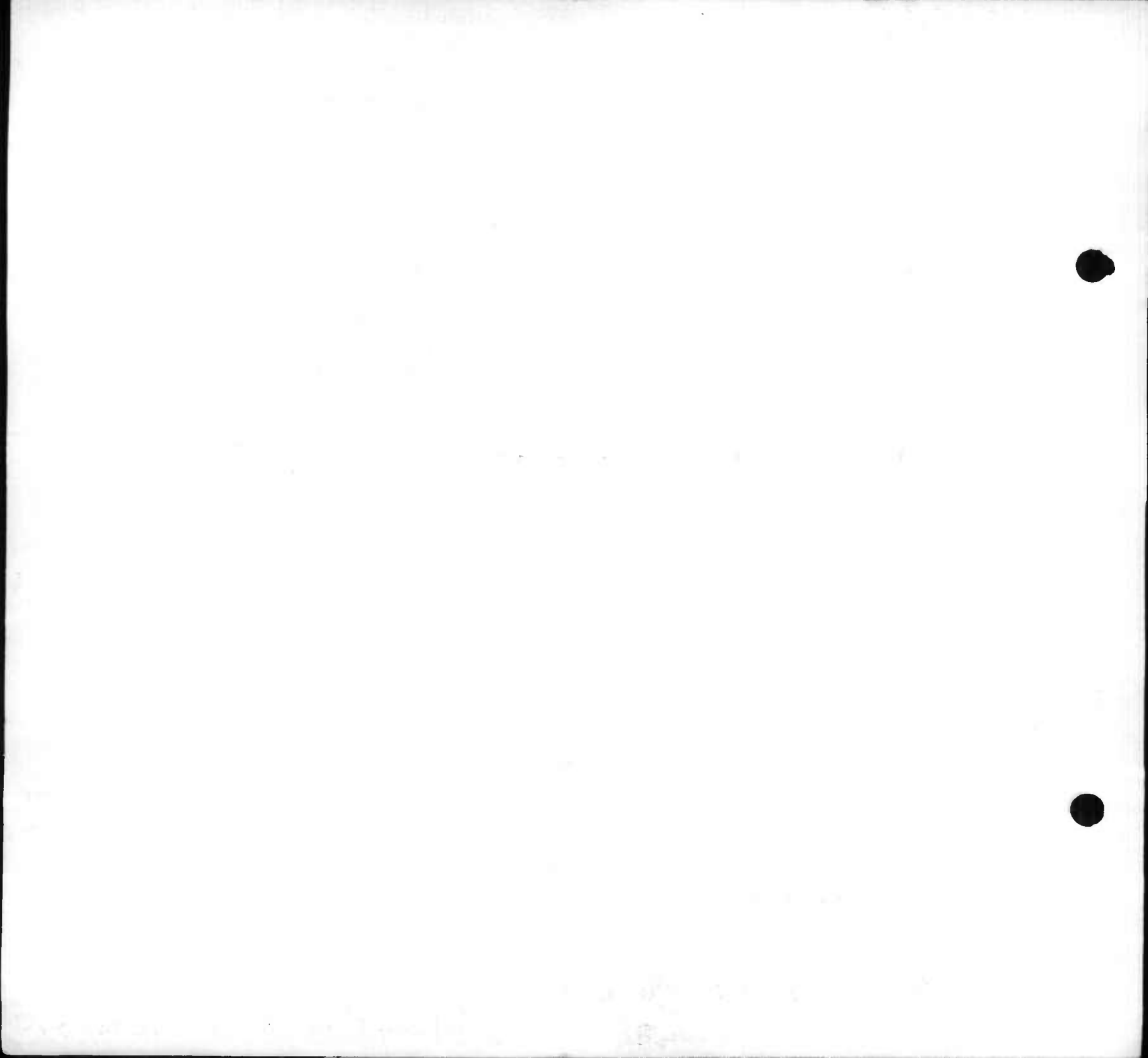
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 6648</u>	
BIRTH NO. <u>A-536 70 6648</u>				1. NAME OF DECEASED (Type or Print) <u>Julius L. Anderson</u>		2. DATE AND HOUR OF DEATH <u>6/30/70</u> <u>6:30</u> a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Church Home + Hospital</u> <u>35</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u>		B. COUNTY <u>Baltimore</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1406 Bay Court</u>			
5. SEX <u>male</u>	6. RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/09</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hamper</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>George Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Roena Thomson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>812018468</u>		17. INFORMANT <u>pat. dept in hosp.</u>		ADDRESS	
18. <u>lung cancer</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>congestive heart failure</u> <u>pneumonia</u>				(C) DUE TO, OR AS A CONSEQUENCE OF:		<u>weeks or months</u> <u>2 weeks</u>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>6/23/70</u> 19 <u>70</u> to <u>6/30/70</u> 19 <u>70</u> that (2) (we) last saw the deceased alive on <u>6/29</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Rolando A. Mendez</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>6/30/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MENDEZ, MD</u>				23D. ADDRESS <u>100 N. Broadway, Balto, MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7/3/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto National</u>		24D. LOCATION (City, town, or county) (State) <u>5501 Frederick Rd, Balto, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Joseph P. Lock, Jr. 1304 N. Central Ave</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

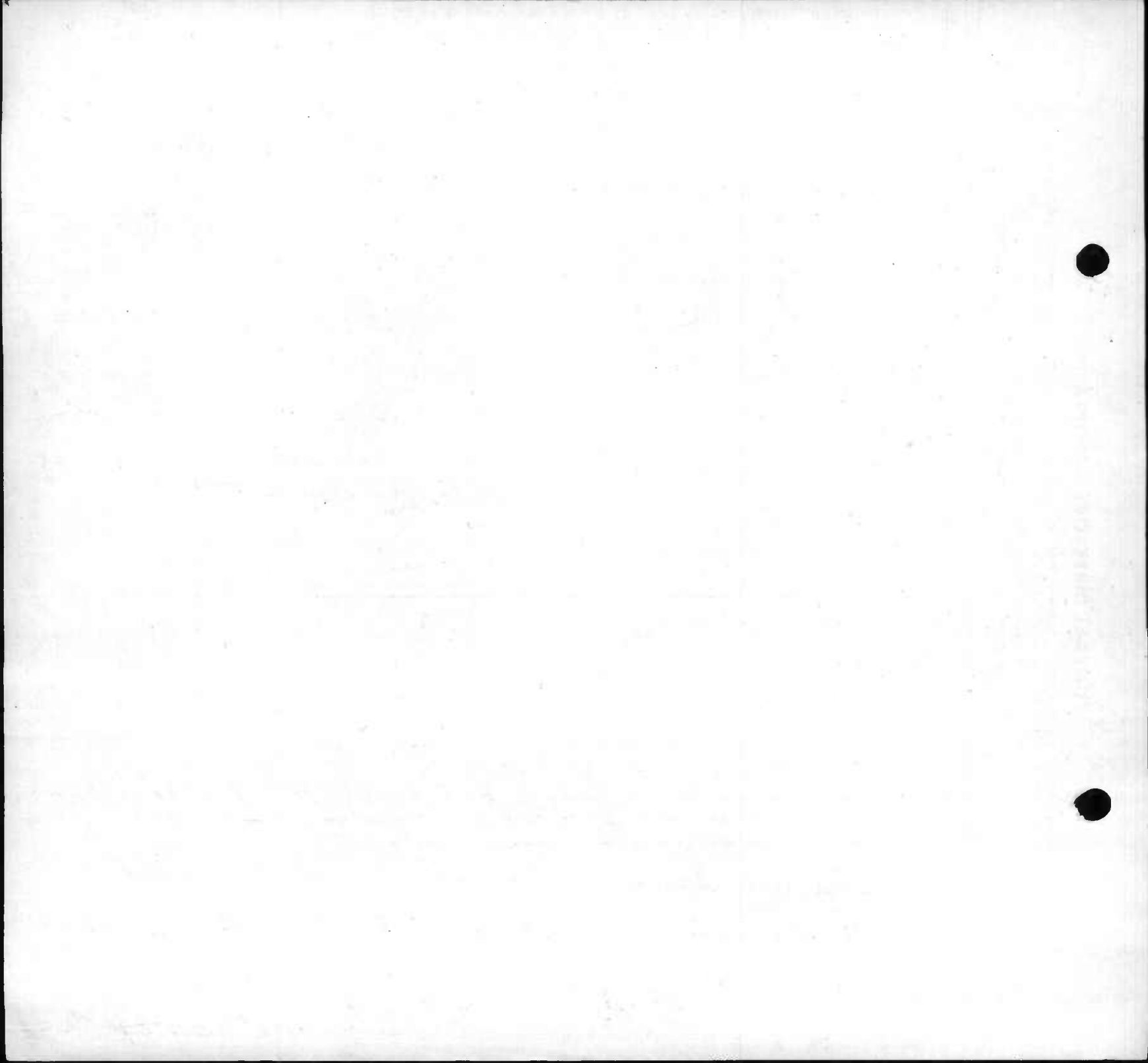
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6649</u>	
C-140 70 6649				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JOHN H. CHAPPLE</u>		2. DATE AND HOUR OF DEATH <u>JUNE 28, 1970</u> <u>8:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CITY</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>49 NORTH CHARLES GENERAL HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>3501 PLATEAU AVENUE</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-1898</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>ALEC CHAPPLE</u>		14. MOTHER'S MAIDEN NAME <u>Indie Robinson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-014821</u>		17. INFORMANT <u>CHAPT</u> ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOGENIC CA</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>6-28-70</u>		23C. PHYSICIAN'S NAME (Type) <u>EDDORO CARANGA</u>	
23D. ADDRESS		23E. PHYSICIAN'S DEGREE		23F. PHYSICIAN'S CATEGORY Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-3-70</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. Auburn</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		24E. FUNERAL DIRECTOR <u>Henry O. Wilson</u>		24F. ADDRESS <u>1000 Brantley Ave.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. NAME OF REGISTRAR <u>Robert E. Taylor</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6650	
<p>BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Elizabeth Porter</i></p>		<p>2. DATE AND HOUR OF DEATH <i>6-20-70 2:45 A.M.</i></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>ANNE ARUNDEL</i></p>			
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mt. Sinai Nursing Home 4613 Park Heights Ave.</i></p>		<p>C. CITY OR TOWN <i>Baltimore</i></p>		<p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <i>501</i></p>	
<p>5. SEX <i>Female</i></p>		<p>6. RACE <i>NEGRO</i></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>8. DATE OF BIRTH <i>4-5-87</i></p>	
<p>13. FATHER'S NAME <i>George Sheppard</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Emily Stratton</i></p>		<p>9. AGE (In years lost birthday) <i>83</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p>16. SOCIAL SECURITY NO.</p>		<p>11. BIRTHPLACE (State or foreign country) <i>Virginia</i></p>	
<p>17. INFORMANT <i>Katherine May Johnson Lane</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>America's</i></p>		<p>ADDRESS</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Carcinoma of breast surg</i> (A) IMMEDIATE CAUSE <i>Due to, or as a consequence of</i> <i>the disease to breast</i> <i>gran etc</i></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i></p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: <i>no</i></p>	
<p>19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(C) DUE TO, OR AS A CONSEQUENCE OF: <i>no</i></p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <i>no</i></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>June 5 1970</i> to <i>June 20 1970</i>, that (I) (we) last saw the deceased alive on <i>June 20 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <i>Manuel Levin</i></p>				<p>23B. DATE SIGNED <i>6/21/70</i></p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN</i></p>				<p>23D. ADDRESS <i>MD 6106 PARK APTS AVE. BALTO-15 MD</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>24B. DATE <i>7-25-70</i></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Sinai Cem.</i></p>	
<p>24D. LOCATION (City, town, or county) (State) <i>Balto Md</i></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1970</i></p>			
<p>25B. NAME OF REGISTRAR <i>Robert E. Taylor</i></p>		<p>25C. FUNERAL DIRECTOR <i>Edwina von Brantley Inc</i></p>			



S-560

70

6651

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

6651

BIRTH NO.

1. NAME OF DECEASED (Type or Print) McKerrett Seymour		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 6 Day 27 Year 70 Hour 250 P.M. Estimated <input checked="" type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hosp		3. DATE PRONOUNCED DEAD Month 6 Day 27 Year 70 Hour 250 P.M.	
6. SEX M	7. RACE Nep	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-7-28		10. AGE (In years last birthday) 42	11. BIRTHPLACE (State or foreign country) Baltimore md
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Ruth Seymour		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes	
17. SOCIAL SECURITY NO. 270-20-0613		18. INFORMANT Adelaide Seymour	
19. E968		ADDRESS Same	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE CranioCerebral and spinal injury DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1801 Homewood 1001			
22D. TIME OF INJURY (APPROX.) 6 27 70 8:30 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Beaten			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Robert E. Taylor, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 6-28-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-1-70	
24C. NAME OF CEMETERY or CREMATORY Baltimore Nat Cem		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Ed Wilson		ADDRESS 1001 Brantley Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6652</u>
<p>BIRTH NO. <u>J-520 70 6652</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>JOHNS, LUCILLE</u></p>		<p>2. DATE AND HOUR OF DEATH <u>6-27-70 5³⁰ A</u></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>45 GOOD SAMARITAN HOSPITAL</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>605</u></p> <p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>201 DOUGLAS CT.</u></p>		
<p>5. SEX <u>F</u></p>	<p>6. RACE <u>NEGRO</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>8-27-16</u></p>	<p>9. AGE (In years last birthday) <u>53</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		
<p>11. BIRTHPLACE (State or foreign country)</p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		
<p>13. FATHER'S NAME <u>Spotey Bogel</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Lucy Bogel</u></p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO.</p>		
<p>17. INFORMANT <u>Robert John Johns</u></p>		<p>ADDRESS <u>Same</u></p>		
<p>18. CAUSE OF DEATH</p>				
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIO PATHY</u></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>POSSIBLE RHEUMATIC FEVER</u></p>				
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 YRS</u></p>				
<p>II</p>				
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>				
<p>19A. DATE OF OPERATION <u>2</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		
<p>20A. AUTOPSY? (Yes or No) <u>YES</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>		
<p>22. I certify that (this hospital) attended the deceased from <u>6-10</u> 19 <u>70</u> to <u>6-27</u> 19 <u>70</u>, that (I) (we) last saw the deceased alive on <u>6-27</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE <u>Michael D. Lutz, M.D.</u></p>				<p>23B. DATE SIGNED <u>6-27-70</u></p>
<p>23C. PHYSICIAN'S NAME (Type) <u>MICHAEL D. LUTZ M.D.</u></p>		<p>23D. ADDRESS <u>GOOD SAMARITAN HOSP.</u></p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burne</u></p>		<p>24B. DATE <u>7-1-70</u></p>		
<p>24C. NAME OF CEMETERY or CREMATORY <u>W. Wilson Cal</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore</u></p>		
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u></p>		
<p>25C. FUNERAL DIRECTOR</p>		<p>ADDRESS <u>Wilson 1002 Brantley Ave</u></p>		

0-25-70

THURSDAY

MD

BALTIMORE

201 BRUCE CT.

8-21-12 24

Good Samaritan Hospital

WEDNESDAY

14142

INFO CARDS PRINTED

ASSISTANT MANAGER FOR

0-25-70

20

0-10-70

0-25-70

Michael A. Lee, M.D.

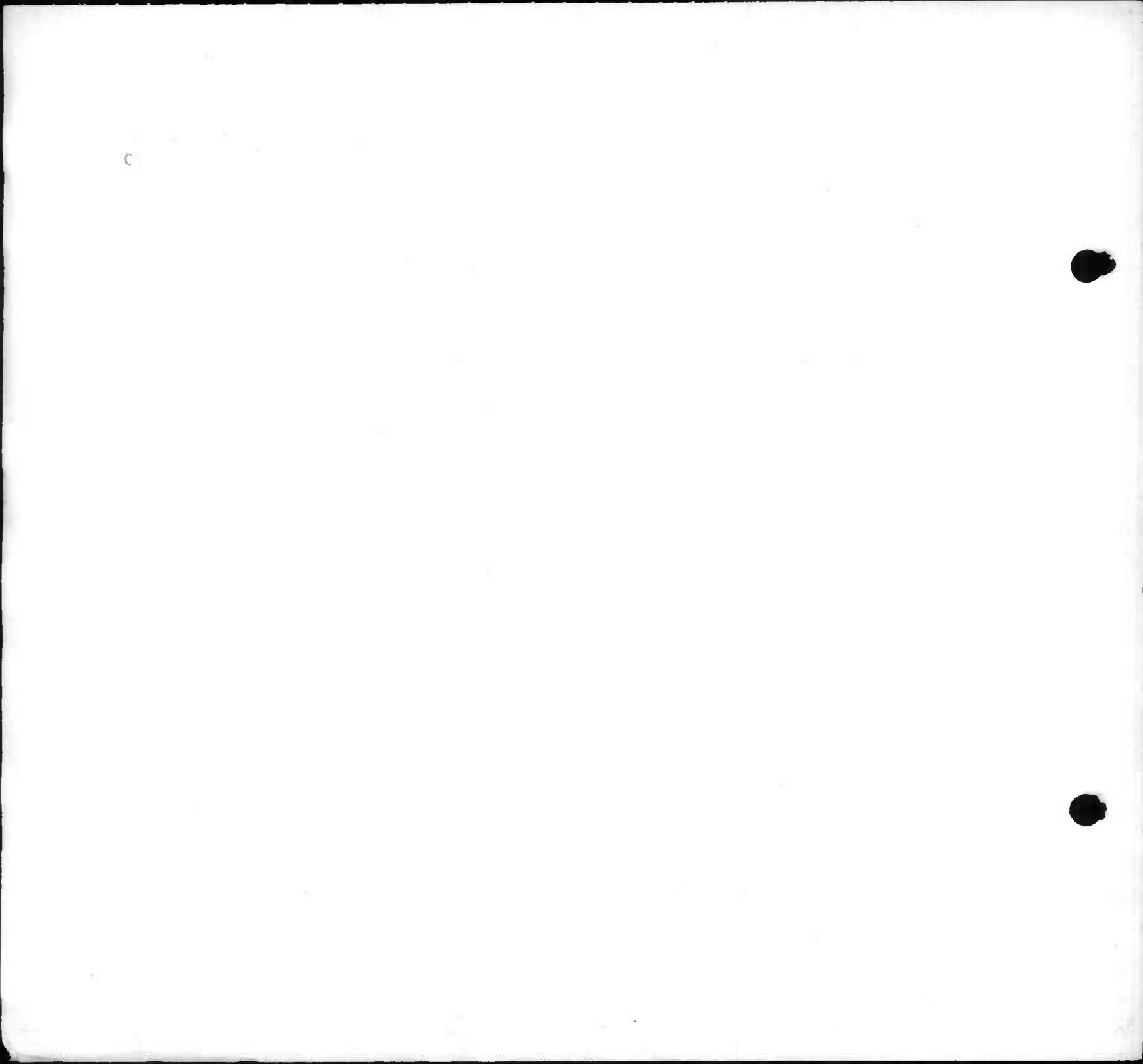
Good Samaritan Hospital

MICHAEL A. LEE, M.D.

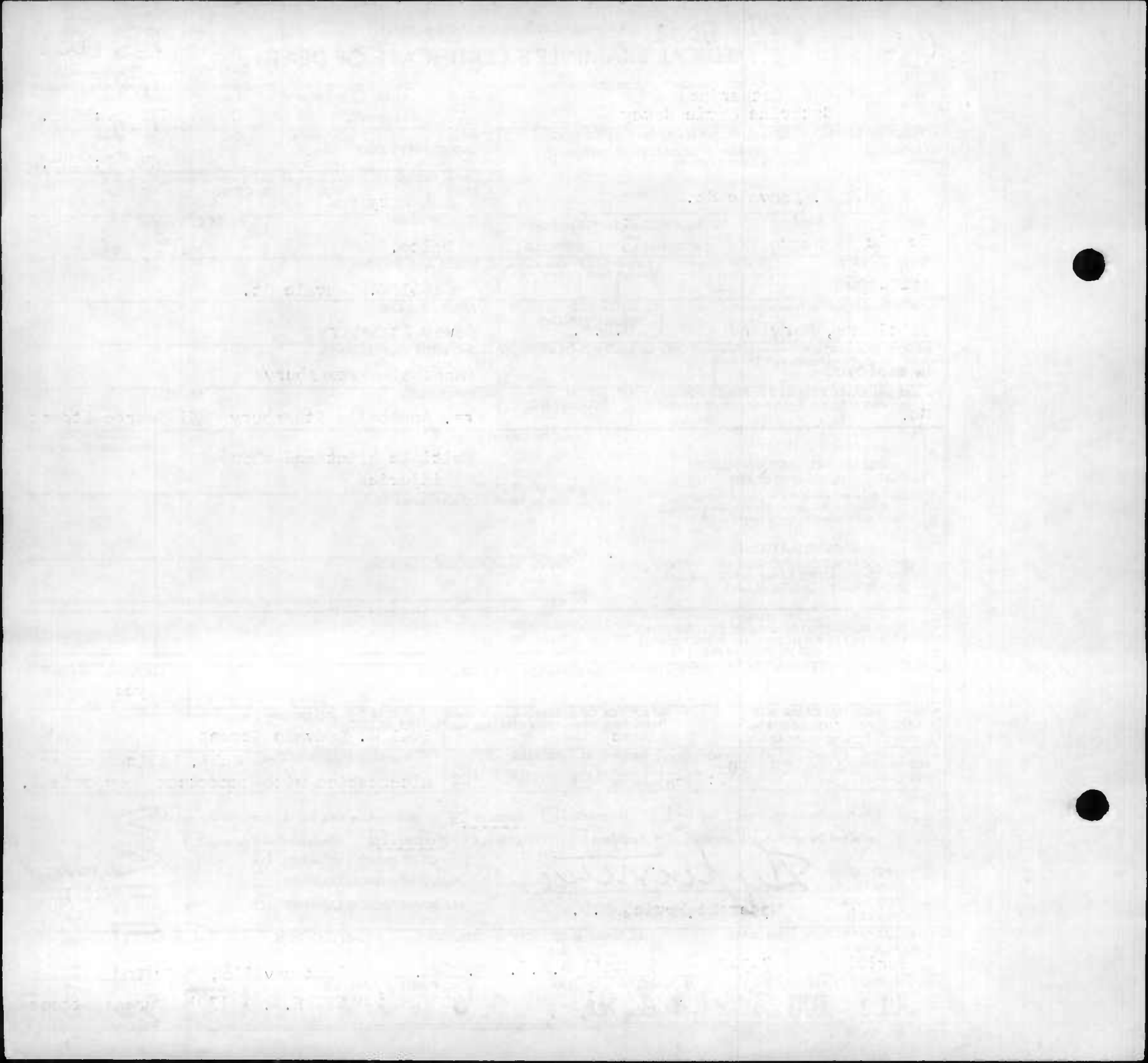
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6653	
BIRTH NO. 70 6653				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Thomas Bowman</i>			2. DATE AND HOUR OF DEATH <i>6/26/70 1830 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University of Maryland Hospital 38</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>Maryland</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1004 N. Carey St.</i>		
5. SEX <i>M</i>	6. RACE <i>N W N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/1/02</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Samuel Bowman</i>			14. MOTHER'S MAIDEN NAME <i>Nellie Washington</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-10-6438</i>	17. INFORMANT <i>Ruth Bowman</i> ADDRESS <i>1004 N Carey St</i>		
18. I <i>15381</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>D.O.A. @ 8:30 PM 6/26/70 CVA.</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CVA.</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Metastatic Ca of Colon</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours.</i>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> that (I) (we) lost saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>J. J. Oldroyd M.D.</i> DEGREE			23B. DATE SIGNED <i>6/26/70</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <i>J. J. Oldroyd M.D.</i> DEGREE			23D. ADDRESS <i>University Hospital</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>6-30/70</i>	24C. NAME of CEMETERY or CREMATORY <i>Mt Auburn Ct</i>		24D. LOCATION (City, town, or county) (State) <i>Balt City</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>Ed Brown</i> ADDRESS <i>12320 Montgomery St</i>	



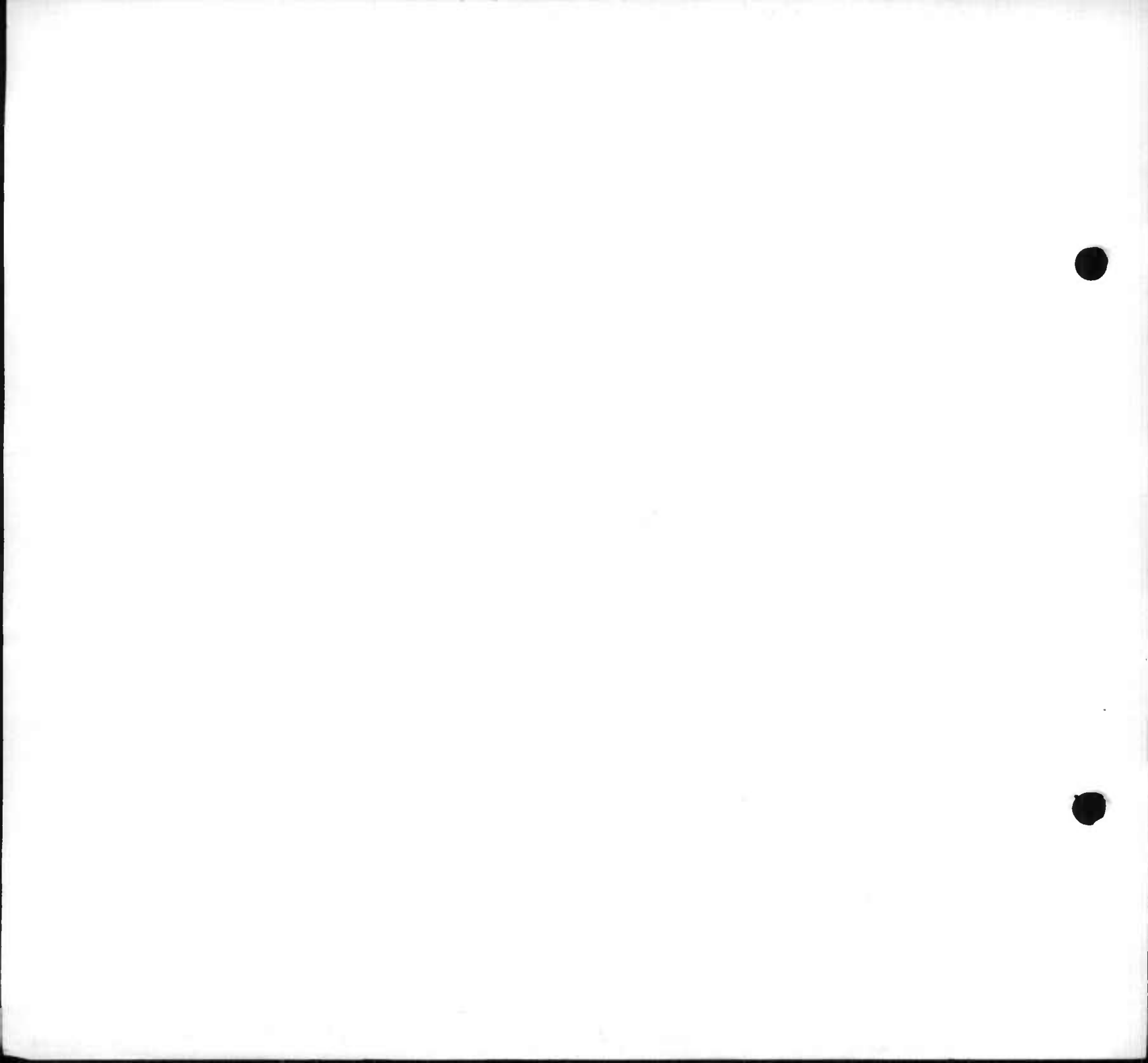
C-600		70 6654		BALTIMORE CITY HEALTH DEPARTMENT		70 6654	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO.	
BIRTH NO.							
1. NAME OF DECEASED (Catherine) (Type or Print) Cathrine Marie Carey				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 6 28 70 7:18 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) OR INSTITUTION 00 1041 W. Lanvale St.				3. DATE PRONOUNCED DEAD Month Day Year Hour 6 28 70 7:18 a.m.			
6. SEX female				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-8-1940				10. AGE (In years last birthday) 29		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME Dewey Stansbury		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1601	
15. MOTHER'S MAIDEN NAME Annabelle Stansbury				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.			
17. SOCIAL SECURITY NO.				18. INFORMANT ADDRESS Mrs. Annabelle Stansbury 851 George Street			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple blunt and sharp injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1041 W. Lanvale Street 1601			
22D. TIME OF INJURY (APPROX.) 6 28 70 7:05-10 a.m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? Subj. killed during altercation with my friend boy friend.				23.			
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.				DATE SIGNED 6/29/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-3-70			
24C. NAME OF CEMETERY or CREMATORY Basil A.M.E. Ch. Cem.				24D. LOCATION (City, town, or county) (State) Cockeysville, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970				25B. NAME OF REGISTRAR Robert E. Jaber, M.D.			
25C. FUNERAL DIRECTOR MORTON & DYETT F.H.				ADDRESS 1701 Laurens Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

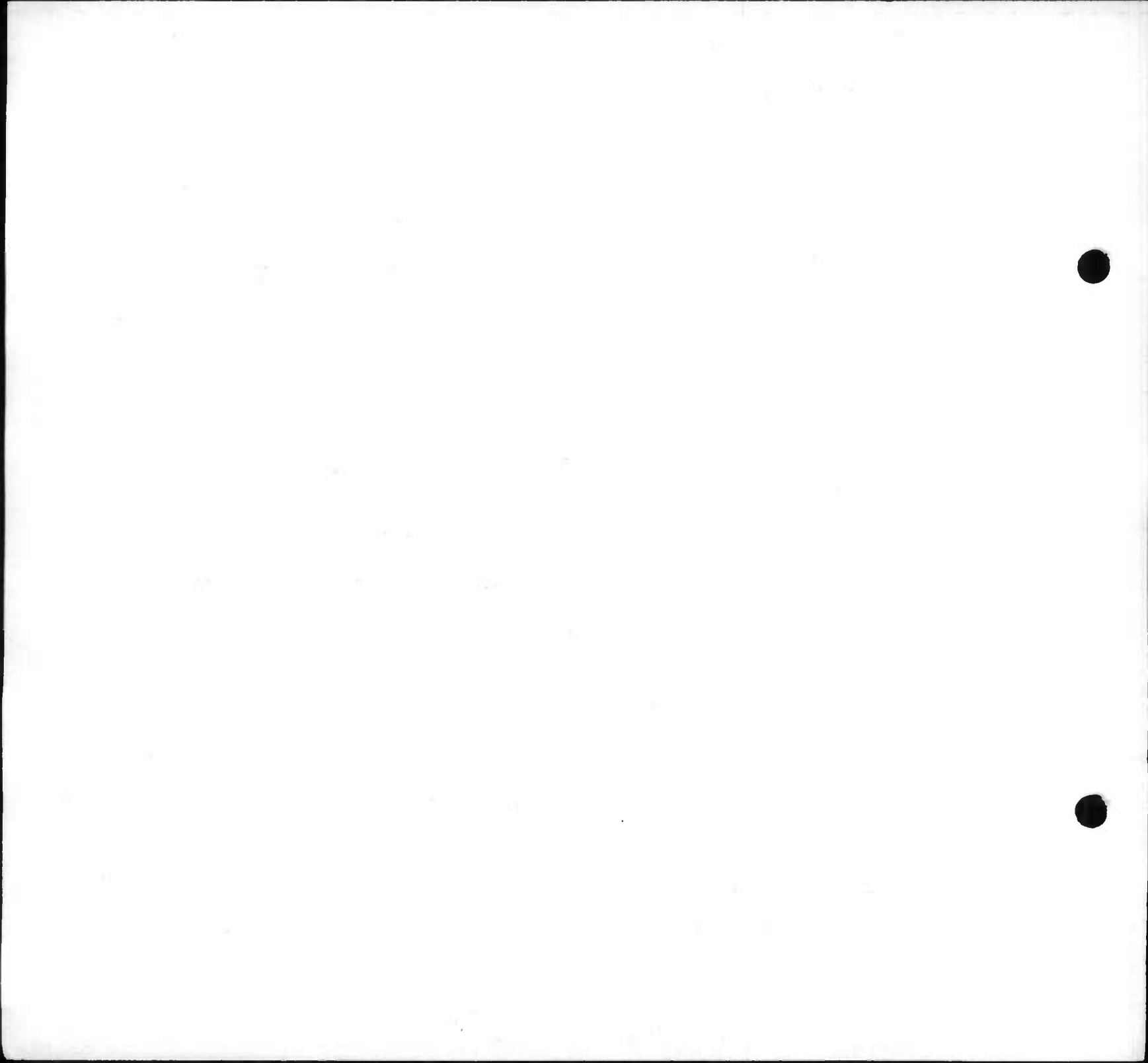
<p>P-625 70 6655</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 70 6655</p>	
<p>BIRTH NO.</p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>1. NAME OF DECEASED (Type or Print) <i>James W. Perkins Jr</i></p>		<p><i>6/30/70 10:15 a.m.</i></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><i>Union Memorial Hospital</i></p>		<p>A. STATE <i>BALTIMORE Md.</i> B. COUNTY <i>2710</i></p>	
		<p>C. CITY OR TOWN <i>BALTO 12</i></p>	<p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>
		<p>E. STREET AND NUMBER <i>4438 Menwood Avenue</i></p>	
<p>5. SEX <i>Male</i></p>	<p>6. RACE <i>negro</i></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <i>05-06-47</i></p>
		<p>9. AGE (In years last birthday) <i>23</i></p>	<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>army</i></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i></p>
<p>13. FATHER'S NAME <i>James W. Perkins</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 10/26/66 - 6/19/70</i></p>		<p>16. SOCIAL SECURITY NO. <i>218-46-1745</i></p>	<p>17. INFORMANT <i>wife</i> ADDRESS <i>the same</i></p>
<p>18. CAUSE OF DEATH</p>			
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE <i>Respiratory arrest.</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Kidney disease. Bronchitis</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <i>6/29</i></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) <i>Yes</i></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>6/27</i> 19 <i>70</i> to <i>6/30</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>6/29</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>[Signature]</i> DEGREE <i>MD</i></p>		<p>23B. DATE SIGNED <i>6/30 70</i></p>	<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>
<p>23C. PHYSICIAN'S NAME (Type) <i>DR VAN KAMMEN MD</i></p>		<p>23D. ADDRESS <i>U.M.H.</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>	<p>24B. DATE <i>7/3/70</i></p>	<p>24C. NAME of CEMETERY or CREMATORY <i>Baltimore Nat'l Cemetery</i></p>	<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <i>JUL 1 1970</i></p>	<p>25B. NAME OF REGISTRAR <i>Robert E. Taylor, Reg.</i></p>	<p>25C. FUNERAL DIRECTOR <i>Morton E. Dyett F.H. 1701 Laurens St.</i></p>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6656</u>	
BIRTH NO. <u>G-416</u>		AGE <u>70</u>		DECEASED <u>6656</u>	
1. NAME OF DECEASED (Type or Print) <u>GILBERT, MORTHA</u>			2. DATE AND HOUR OF DEATH <u>6/29/70</u> <u>16²⁵</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>CORANADA Nursing Home Inc.</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7 N. CARLTON ST.</u>		
5. SEX <u>F</u>	6. RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/19/23</u>	9. AGE (In years lost birthday) <u>47</u>	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>
13. FATHER'S NAME <u>Charles Bryant</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>-0-</u>		17. INFORMANT <u>med. cal Records.</u> ADDRESS
18. <u>189001</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>anemia & ataxia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>adenocarcinoma of endometrium</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>metastasis in colon (colostomy)</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Dehydration</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 24</u> 19 <u>70</u> to <u>June 29</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>June 26</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rafael A. Santayana</u>			23B. DATE SIGNED <u>June 29-70</u>		23C. PHYSICIAN'S NAME (Type) <u>RAFAEL A. SANTAYANA</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7/2/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>			25C. FUNERAL DIRECTOR <u>Morton & Dyer F.H.</u> ADDRESS <u>1701 Laurens St.</u>		



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BALTIMORE CITY HEALTH DEPARTMENT				70 6657		REG. NO.	
BIRTH NO.				70 6657			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
LOTTIE A. BISHOP				JUNE 27th 1970 1:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 1327 1/2 FULTON AVE.				MARYLAND, BALTIMORE 1502			
5. SEX Female				6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
				WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
						7-31-1892	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Retired						77	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY			
Baltimore, Maryland				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Wossup				Charlotte			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No.						ADDRESS	
						MRS. PEARL BISHOP 1327 1/2 Fulton Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)				H.C.V.D.; A.S.H.D. -			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				Cerebral Ischemic			
				osteomyelitis			
				(C) Congestive Heart Failure			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				5 yrs			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0						NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
N/A				N/A		N/A	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCURRED	
N/A				N/A		N/A	
22. I certify that (I) (the hospital) attended the deceased from 5/13/70 to 6/26/70 that (I) (we) last saw the deceased alive on 6/26/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
[Signature]				6/29/70		V. H. MAN RAY JR., M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial				7-1-70		Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 1 1970				Robert E. Farber, R.D.		MORTON & DYETT F.H.	
						ADDRESS	
						1701 Laurens Street	

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General Information

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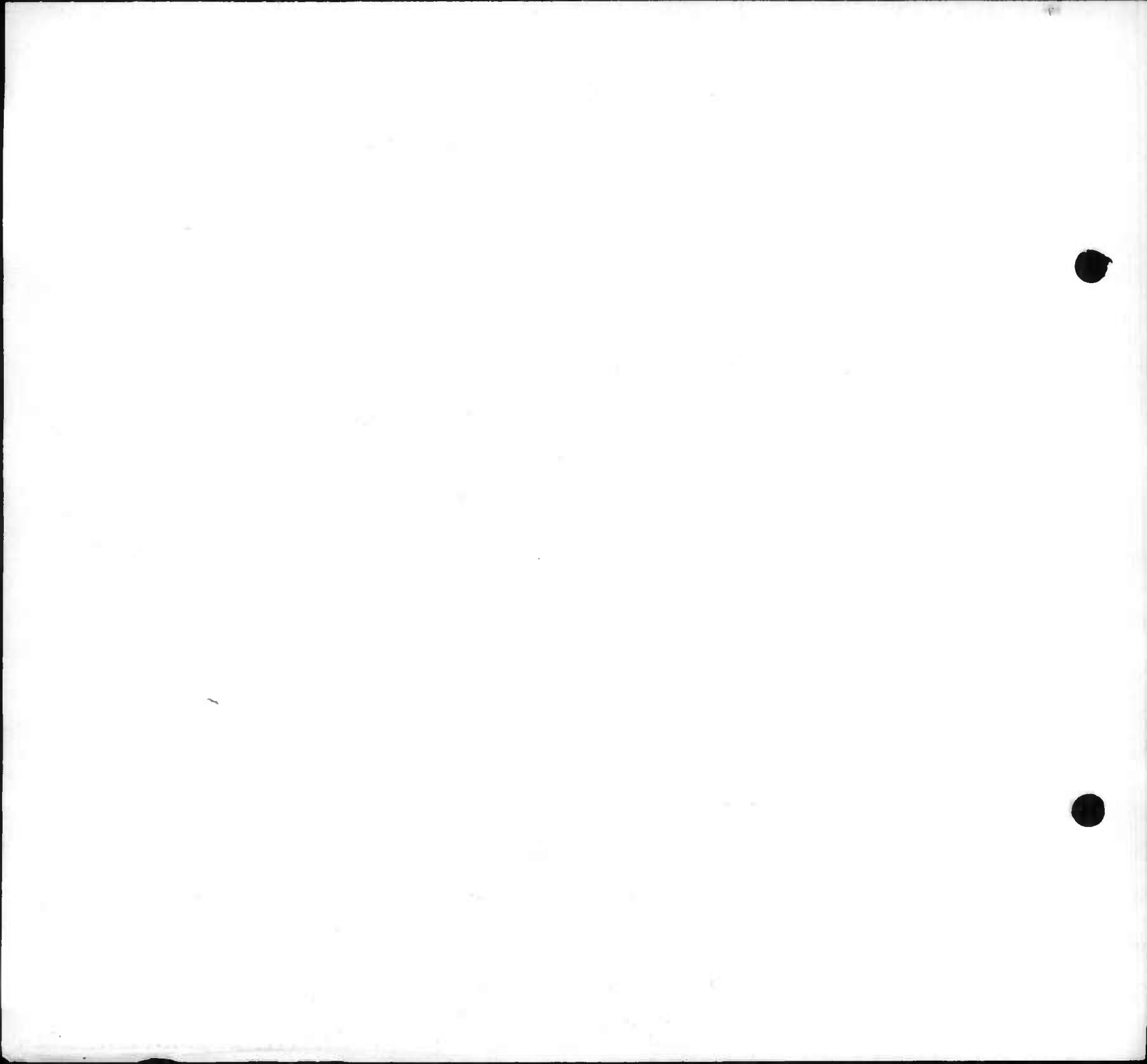
1-1-1

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-400		70 6658		BALTIMORE CITY HEALTH DEPARTMENT		70 6658	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ODELIA GALLOWAY</u>				2. DATE AND HOUR OF DEATH <u>6/28/70</u> <u>11:05 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>380 UNIVERSITY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1801</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>208 N. Amity Street</u>			
5. SEX <u>F</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-09</u>	9. AGE (In years last birthday) <u>61</u>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY				13. FATHER'S NAME <u>Robert Williams</u>			
14. MOTHER'S MAIDEN NAME <u>Eliza Williams</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>William Galloway</u> ADDRESS <u>208 N. Amity St.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic Cardiovascular Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Recent Myocardial Infarction</u> <u>Probable acute Myocardial Infarction 1 day.</u>				CAUSE OF DEATH <u>Arteriosclerotic Cardiovascular Disease</u> (A) IMMEDIATE CAUSE <u>With</u> <u>Recent Myocardial Infarction</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Probable acute Myocardial Infarction 1 day.</u>			
19. DATE OF OPERATION				19A. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <u>No</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(did not)</u> attended the deceased from <u>5/28</u> 19 <u>70</u> to <u>6/28</u> 19 <u>70</u> that (I) <u>(did)</u> last saw the deceased alive on <u>June 19</u> 19 <u>70</u> and that <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> <u>(We)</u> <u>(did)</u> <u>(do not)</u> view the body after death.							
23A. SIGNATURE <u>H. C. ALEXANDER</u>				23B. DATE SIGNED <u>June 28, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>H. C. ALEXANDER</u>				23D. ADDRESS <u>1209 SA. Paul St. Balt. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>7/2/1970</u>			
24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial</u>				24D. LOCATION (City, town, or county) (State) <u>Arbutus Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Sabin, M.D.</u>			
25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>				25D. ADDRESS <u>319 N. Schuman St.</u>			



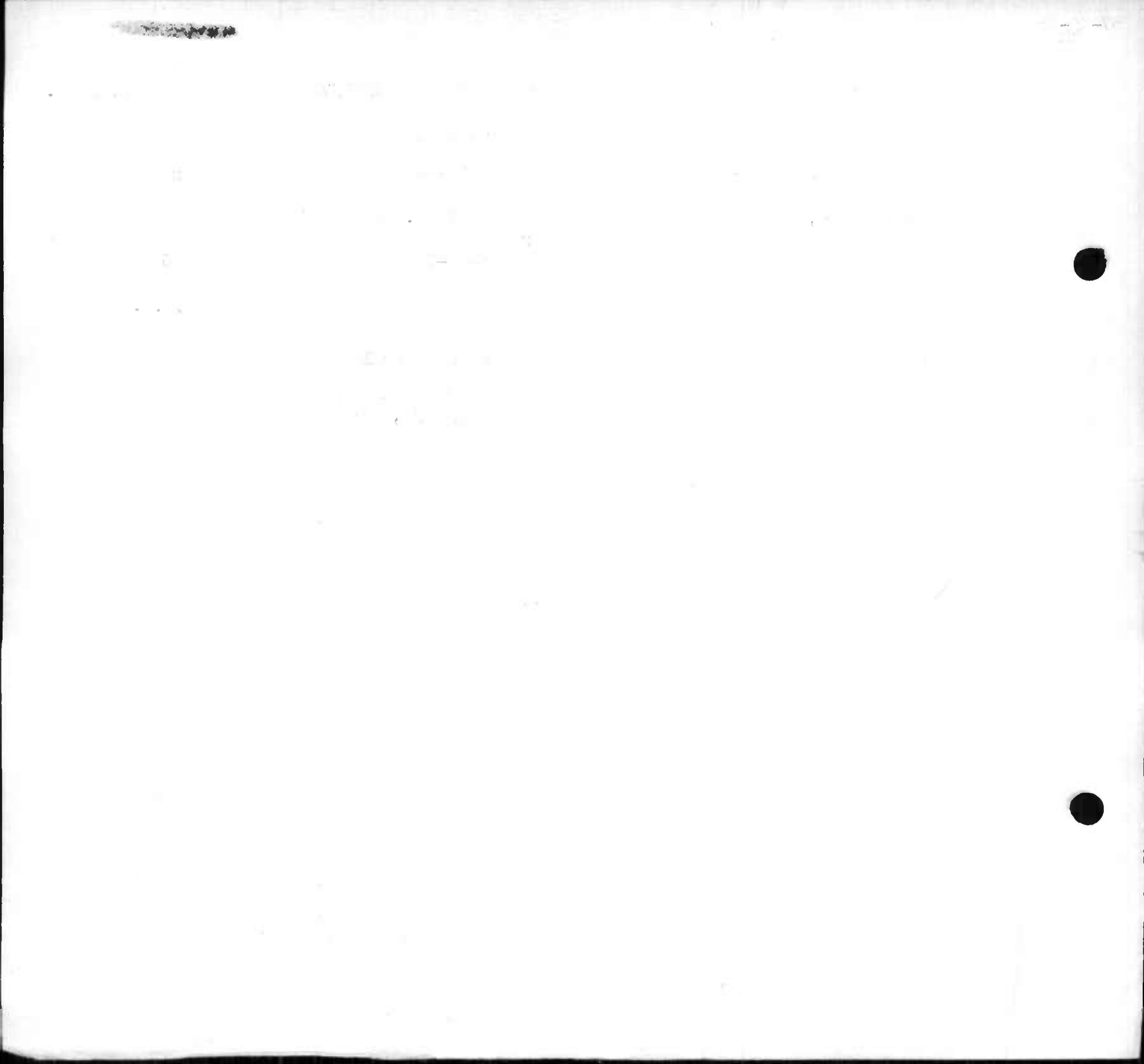
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

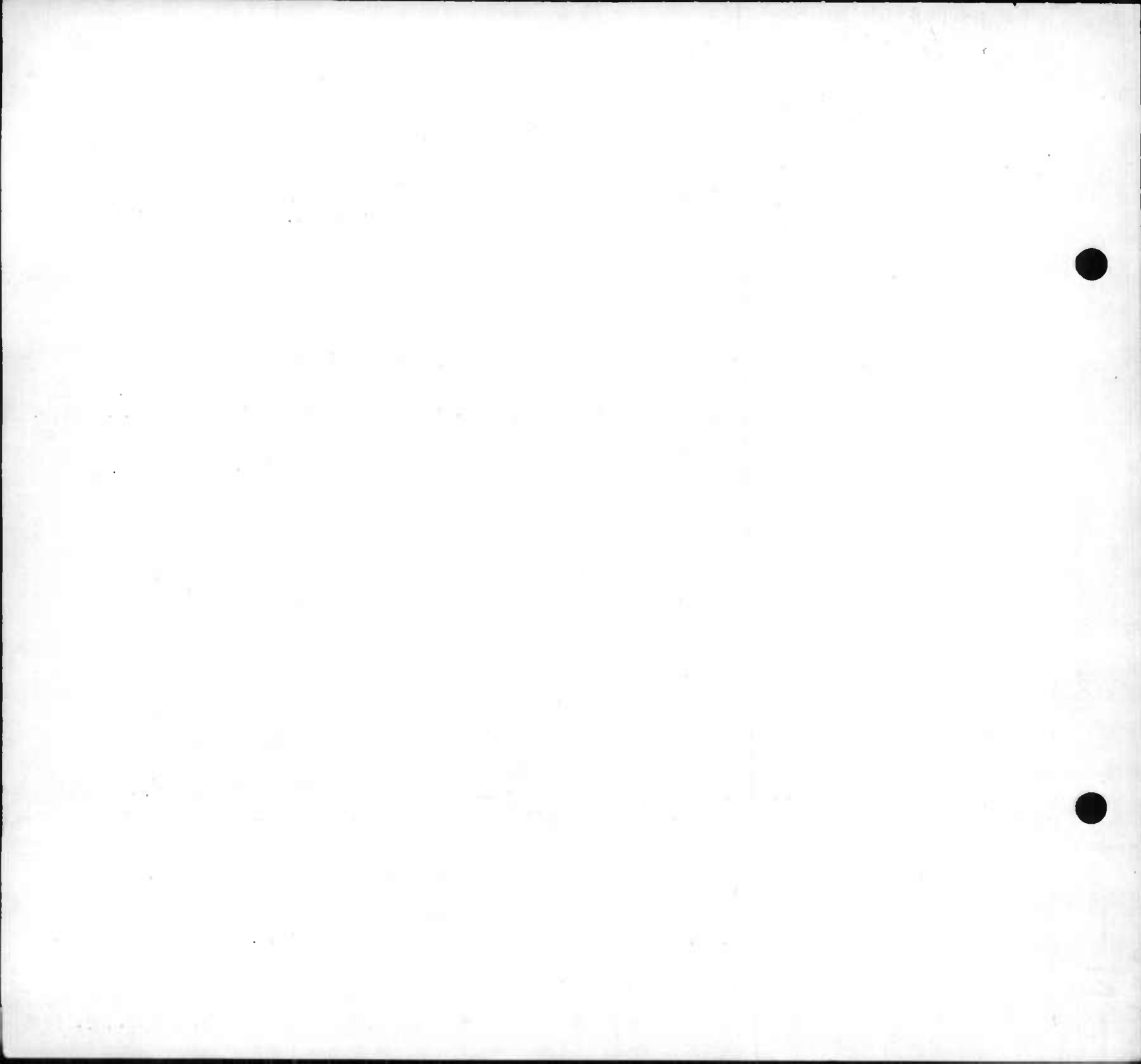
BIRTH NO. M-324 70 6659		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6659	
1. NAME OF DECEASED (Type or Print) MITCHELL BABY GIRL, JEAN			2. DATE AND HOUR OF DEATH 6/23/70 10:45 PM.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 BALTIMORE CITY HOSPITALS Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1510		
5. SEX female			6. RACE Negro		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6-18-70		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME James			14. MOTHER'S MAIDEN NAME Jean Jerrell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			ADDRESS		
18. 038.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PEPSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PREMATURITY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6/23		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/18/70 to 6/23/70 that (I) (we) last saw the deceased alive on 6/23/70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Alvarez			23B. DATE SIGNED 6/24/70		
23C. PHYSICIAN'S NAME (Type) M. ALVAREZ			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE June 24, 1970		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. LOCATION (State) 21224			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

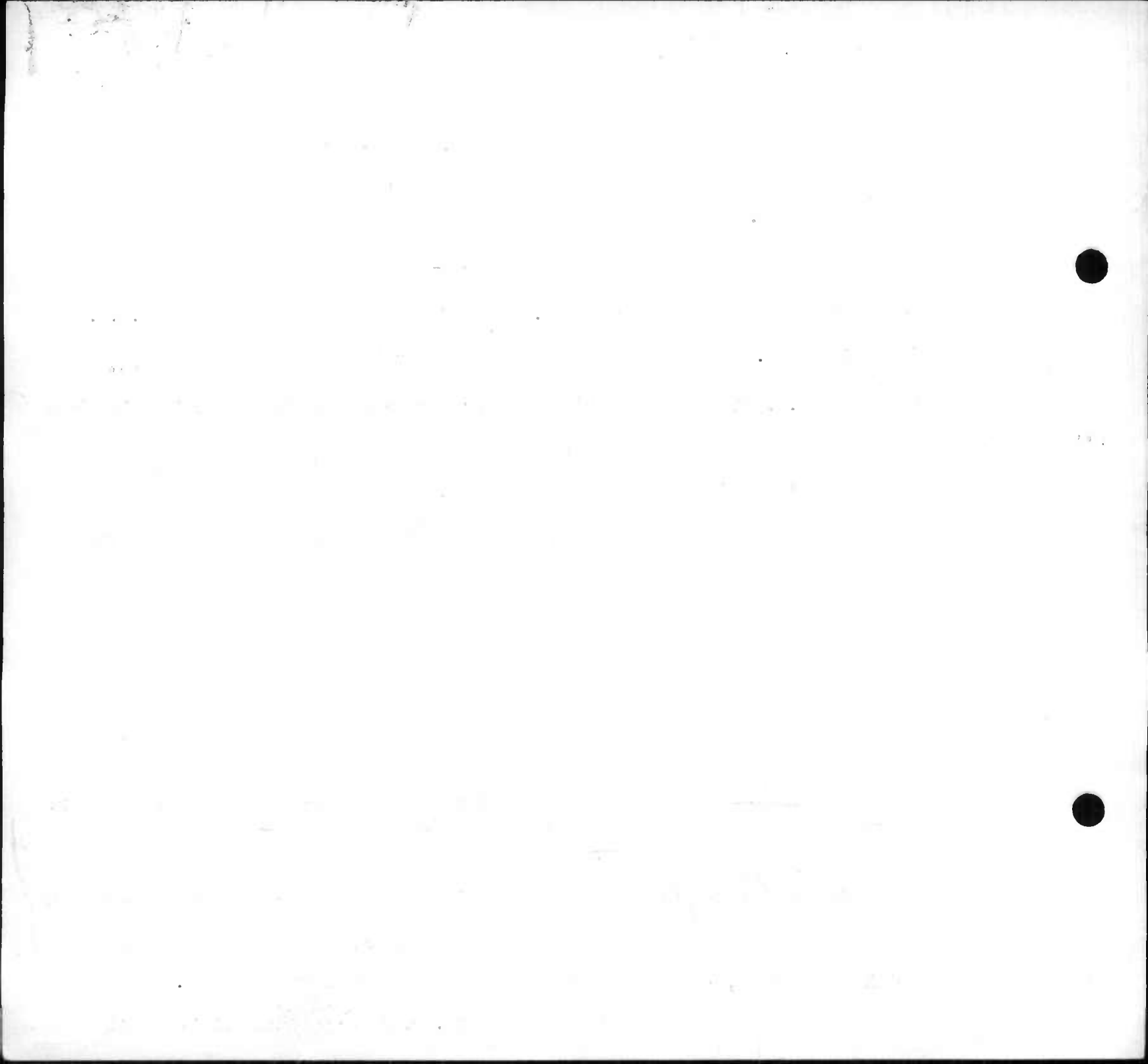
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 6660	
BIRTH NO. 4-640 70 6660				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Lillian M. Hurley			2. DATE AND HOUR OF DEATH 6/29/70 8:30		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2488 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3519 Hayward Ave.		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/04	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME (late) Harry Hurley			14. MOTHER'S MAIDEN NAME Margaret Knight		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-05-9518		17. INFORMANT Mr. Berkeley Shaffer, 3519 Hayward Ave., Balto.
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A. S. H.D. About 5 years (B) Arteriosclerosis About 7 years (C) Rheumatoid Arthritis About 7 years			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from June 5th 19 70 to 6/29/70 19 70 and that (I) (we) lost saw the deceased alive on June 5th 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Julius C. Gluck, M.D.				23B. DATE SIGNED 6/30/70	
23C. PHYSICIAN'S NAME (Type) Julius Gluck, M. D.				23D. ADDRESS 5356 Reisterstown Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/70		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970			
25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Av., Balto., Md. 21229			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-260</u> <u>70</u> <u>6661</u>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. <u>70</u> <u>6661</u>	
1. NAME OF DECEASED (Type or Print) <u>Wysor, Richard T.</u>				2. DATE AND HOUR OF DEATH <u>6/27/70</u> <u>1</u> <u>9:22 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 St. Agnes Hospital</u> <u>900 Caton Ave.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Howard</u> <u>6300</u> C. CITY OR TOWN <u>Columbia</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>10546 Morning Wind Lane</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-22</u>	9. AGE (in years last birthday) <u>47</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Sand & Gravel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>late William W. Wysor</u>				14. MOTHER'S MAIDEN NAME <u>late Mamie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. 11</u>		16. SOCIAL SECURITY NO. <u>213 18 9679</u>		17. INFORMANT <u>Mrs Margaret Wysor</u> ADDRESS <u>10546 Morning Wind Lane</u>			
18. <u>410.7 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Acute myocardial infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 immediate</u> <u>3 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 8</u> <u>19 69</u> to <u>June 27</u> <u>19 70</u> that (I) (we) last saw the deceased alive on <u>June 19</u> <u>19 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Charles E. Taylor</u> M.D.				23B. DATE SIGNED <u>June 29, 1970</u>		23C. ADDRESS <u>Columbia Hosp. + Clinic Fund. Columbia Howard Co. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 1, 1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn</u>		24D. LOCATION (City, town, or county) (State) <u>Woodlawn</u> <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 1 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Howard County</u> ADDRESS <u>Fun. Home Harry Witzke Ellicott City</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 6662		CERTIFICATE OF DEATH		70 6662	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LILLIAN M. SCOTT		6/28/70 1:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
MERCY HOSPITAL		MARYLAND			
5. SEX		6. RACE			
F		N			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8/13/1916			
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
53		HOUSEWIFE			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
MARYLAND		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
HOWARD H. DORSEY		JOSEPHINE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		NONE		BRENDA YOUNG 2414 FREDERICK AVENUE	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Acute Myocardial Infarction			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Hypertensive Cardiovascular disease			
II		(C) Hypertensive Cardiovascular disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 6/26/70 to 6/28/70		22. I certify that (1) (we) last saw the deceased alive on 6/28/70		22. I certify that (1) (we) last saw the deceased alive on 6/28/70	
and that (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
MANUELA RIBEIRO, MD.					
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
MANUELA RIBEIRO, MD.		MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		7/2/1970		ARBUTUS MEMORIAL PARK	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 1 1970		Robert E. Taylor, R.D.		NUTTER FUNERAL HOME 3035 W. NORTH AVE	

Barclay ST.

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BALTIMORE CITY HEALTH DEPARTMENT

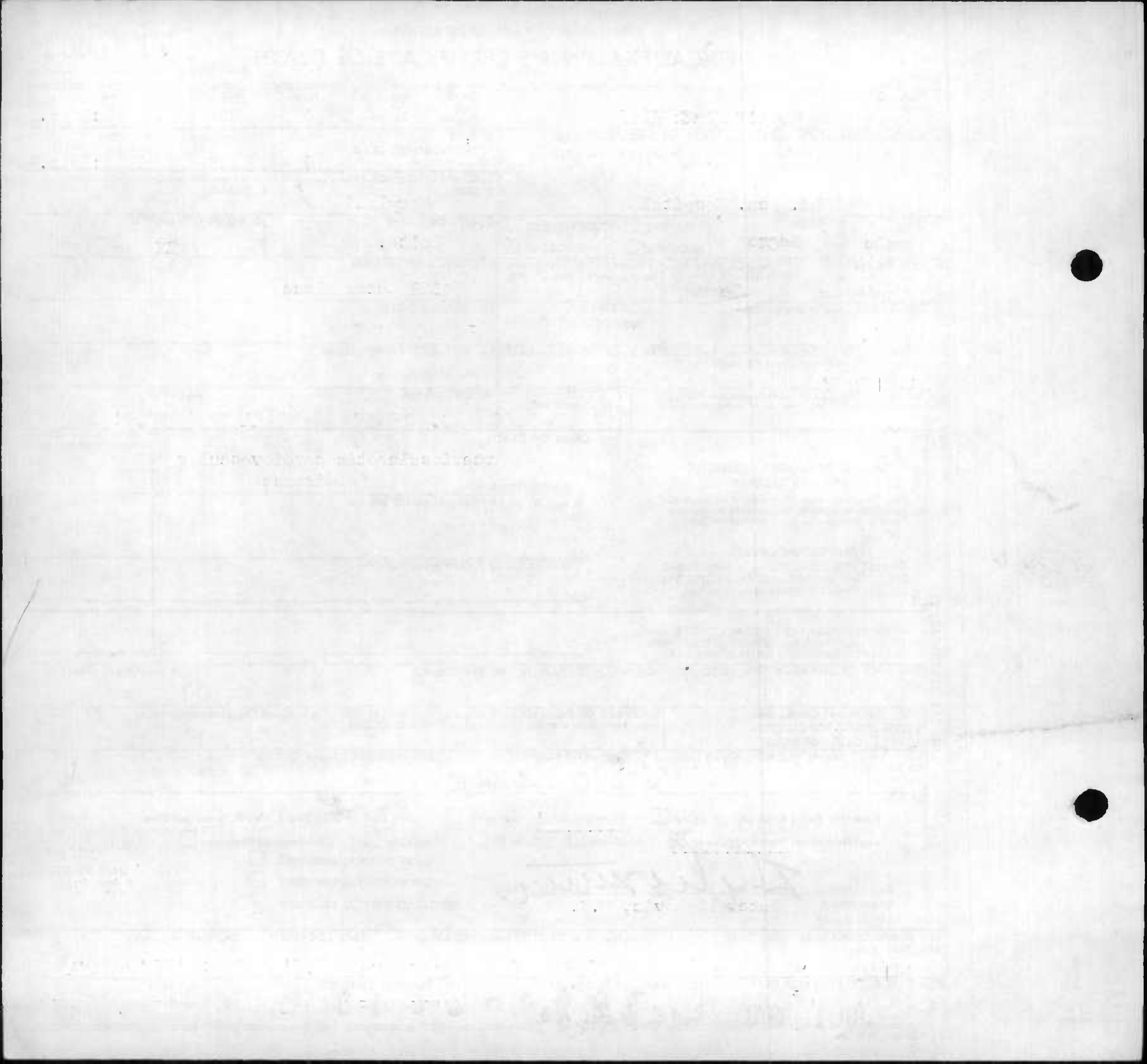
70 6663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6663

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRISON C. BURTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 28 70 8:15 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Md. Gen. Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 28 70 8:15 a.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1401	
9. DATE OF BIRTH 2/22/1896		10. AGE (In years lost birthday) 74 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK BURTON		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITORY	
15. MOTHER'S MAIDEN NAME ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 217-05-7276		18. INFORMANT MRS. GENEVA RANDALL	
19. 42.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION ?		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/29/70	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/3/1970	
24C. NAME of CEMETERY or CREMATORY WESTERN STAR CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE COUNTY MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR OUTER FUNERAL HOME		ADDRESS 3035 W. NORTH AV	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6664

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Samuel Lyles		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 6 30 70 10:28 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1707 Ruxton Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 30 70 10:28 p.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1503		6. SEX male 7. RACE colored 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH April 13, 1909 10. AGE (In years last birthday) 61		11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Lyles		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance	
15. MOTHER'S MAIDEN NAME Nora Delaney		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II	
17. SOCIAL SECURITY NO. 212-10-7464		18. INFORMANT Myrtle G. Lyles ADDRESS 1707 Ruxton Avenue	
19. 412.4 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/30/70	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 7/3/70	
24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Barber, M.D.	
25C. FUNERAL DIRECTOR Butter Funeral Home		ADDRESS 3035 W. North Ave	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-6201

70 6665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 6665

BIRTH NO.

1. NAME OF DECEASED

Anna REBECCA DORSEY

2. DATE AND HOUR OF DEATH

6/29/70 9:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

NORTH CHARLES GEN. HOSP.
49

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

887 West Boulevard ST. 1803

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

5/21/05

9. AGE (In years last birthday)

65

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

ALBERT BROOKS

14. MOTHER'S MAIDEN NAME

SARAH STEWART

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

METASTATIC CANCER

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CA of Breast

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Months

years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 6/2/70 19 70 to 6/29 19 70 that (I) (we) last saw the deceased alive on 6/29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Gracilio V. Patricio

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

6/29/70

23C. PHYSICIAN'S NAME (Type)

GRACILIO V. PATRICIO

DEGREE

23D. ADDRESS

NORTH CHARLES GEN. HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/3/70

24C. NAME OF CEMETERY OR CREMATORY

Mt. CALVERY

24D. LOCATION

Brooklyn, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 1 1970

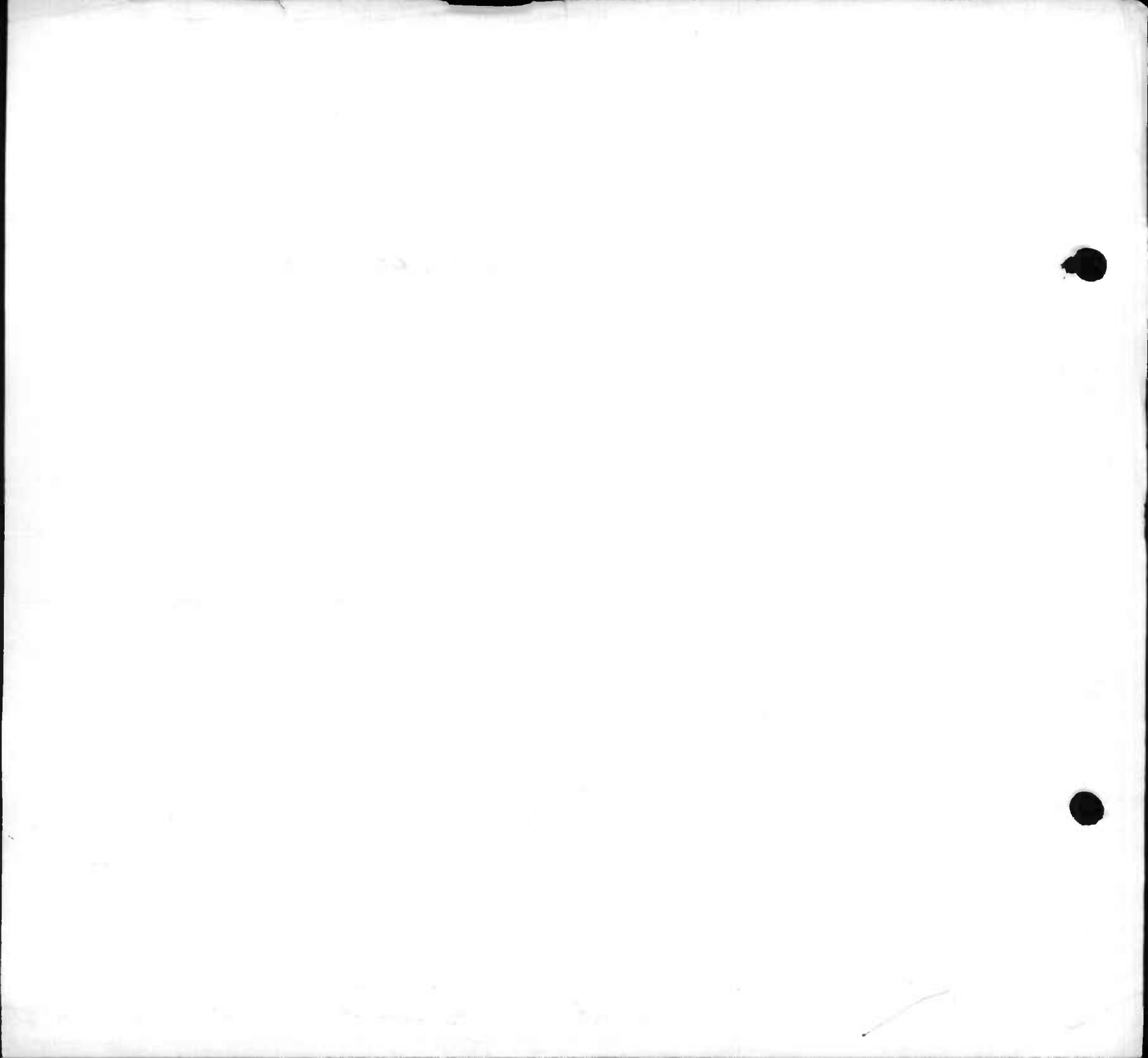
25B. NAME OF REGISTRAR

Robert E. Barber, M.D.

25C. FUNERAL DIRECTOR

CHARLES A. RICE 661 W. BARRE ST.

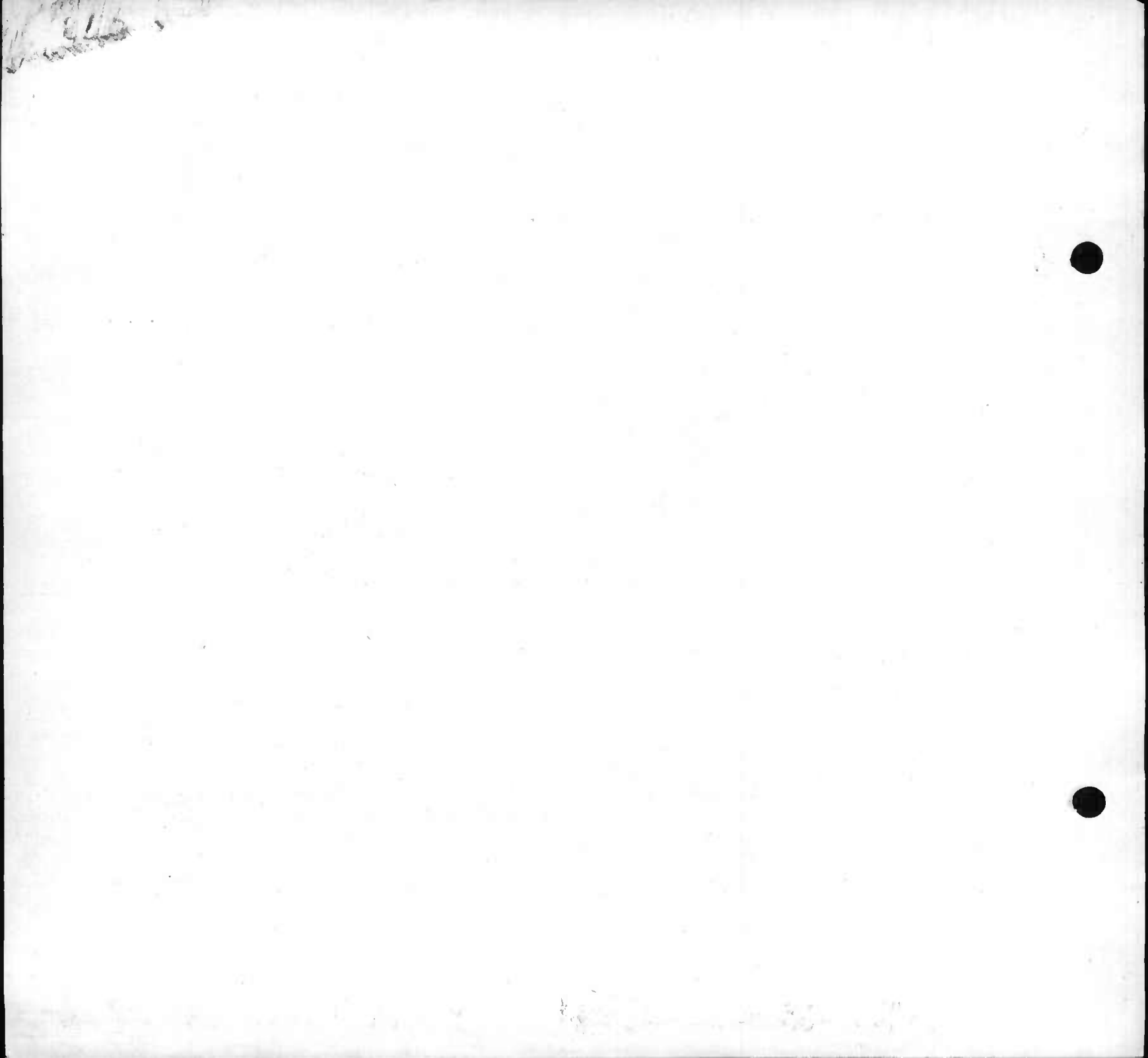
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

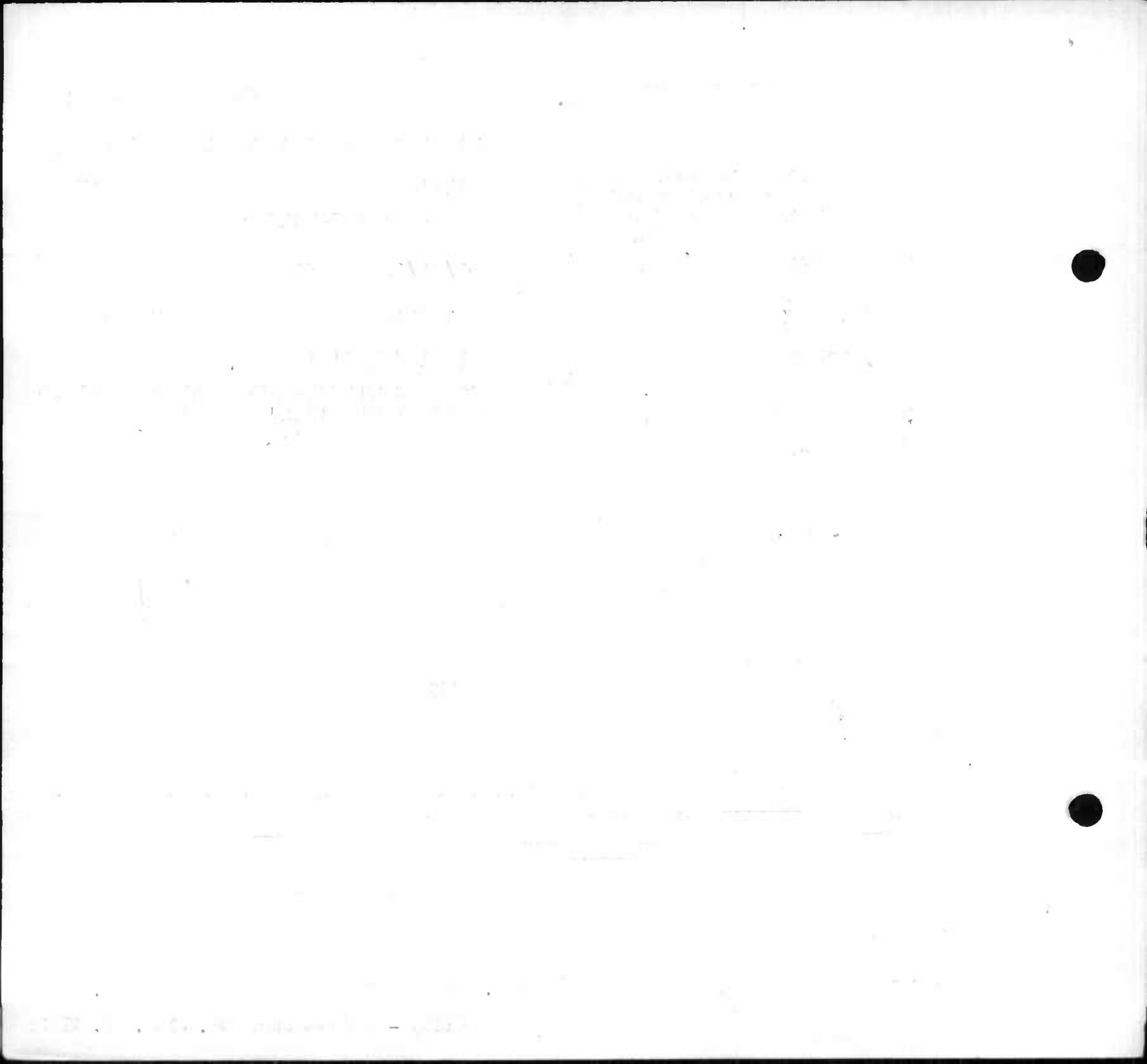
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6668	
M-600 70 6668				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARROW, Augusta			2. DATE AND HOUR OF DEATH June 30, 1970 4:45 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Bolton Hill Nursing & Convalescent Ctr. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1002		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 937 Valley Street 21202		
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-12-94	9. AGE (in years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 412.3 17-174X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery Disease (B) arteriosclerotic heart disease (C) cerebral artery disease		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes yes 19.67					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/31 1967 to 6/30 1970, that (I) (we) last saw the deceased alive on 6/30 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ae Martin				23B. DATE SIGNED 8/1/70	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MAENT M.D.				23D. ADDRESS 2 E Red St Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-70		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) A.A. County, Md					
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS Joseph L. Russ 2222 N North Ave	



FUNERAL DIRECTOR: IMPORTANT

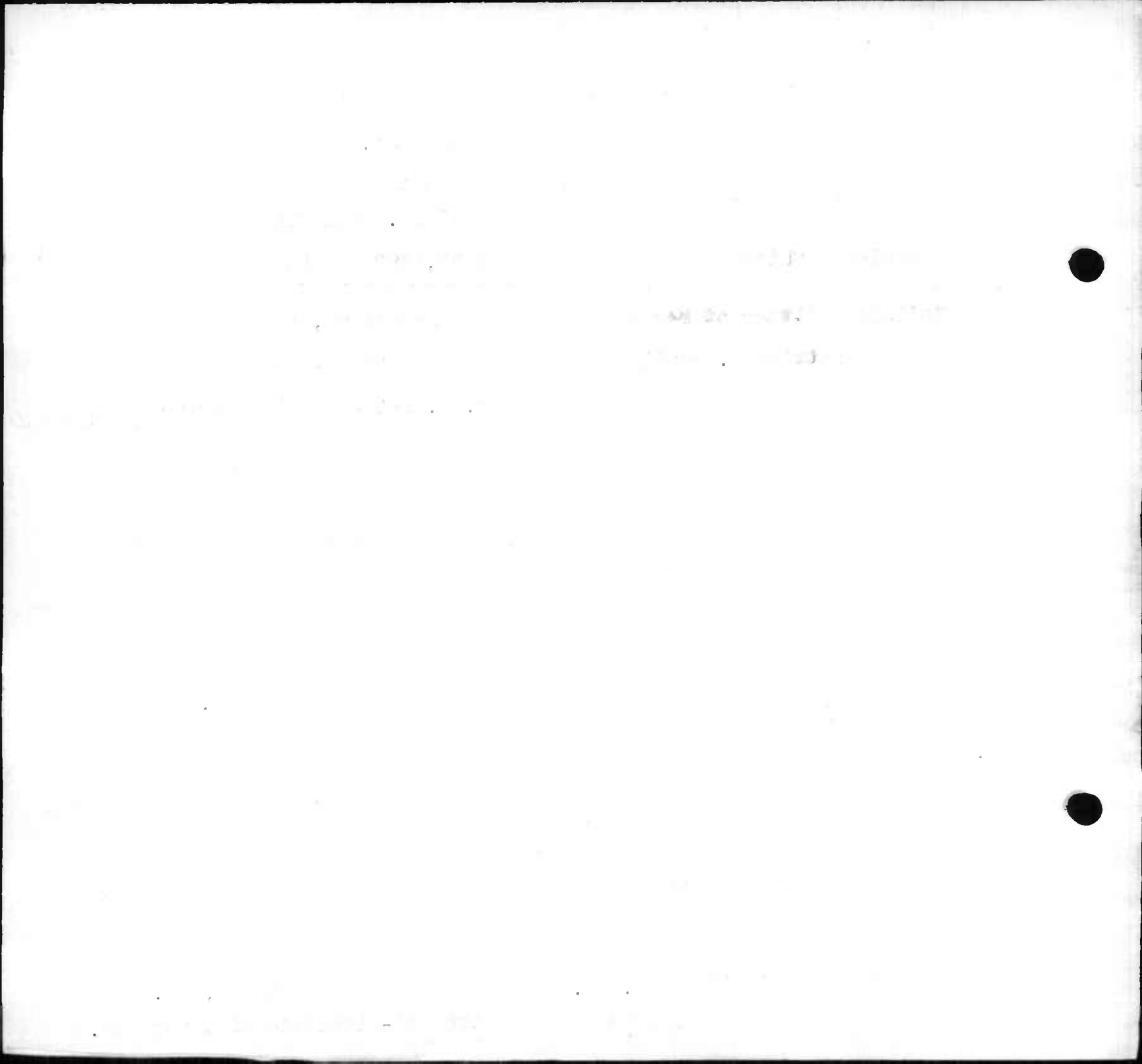
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6667</u>
BIRTH NO. <u>V-426</u>		70 6667		
1. NAME OF DECEASED (Type or Print) VULGARIS, JOHN Sr.		2. DATE AND HOUR OF DEATH JUNE 29, 1970 6:45 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL 21225 5200 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 222 WEST EDGEVALE ROAD		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RESTAURANTEUR		8. DATE OF BIRTH 07/31/12	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN VULGARIS		14. MOTHER'S MAIDEN NAME ANNA (MARTINI)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT CATON & WILKENS AVES BALTO MD 21229 ST AGNES HOSPITAL'S RECORDS
18. 7/2/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Advanced abscess of Lung, Rt.</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Chronic bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Rheumatoid arthritis</i> (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 7/2/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from JUNE 17 19 70 to JUNE 29 19 70 that (X) (we) last saw the deceased alive on JUNE 29 19 70 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Ching-Hui Tsai, M.D.</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Ching-Hui Tsai, M.D.
23D. ADDRESS St Agnes Hosp.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 2, 1970		24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Park
24D. LOCATION (City, town, or county) (State) Glen Burnie, AA Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR McCully - 237 Patapsco Ave. Balto. Md. 21225



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

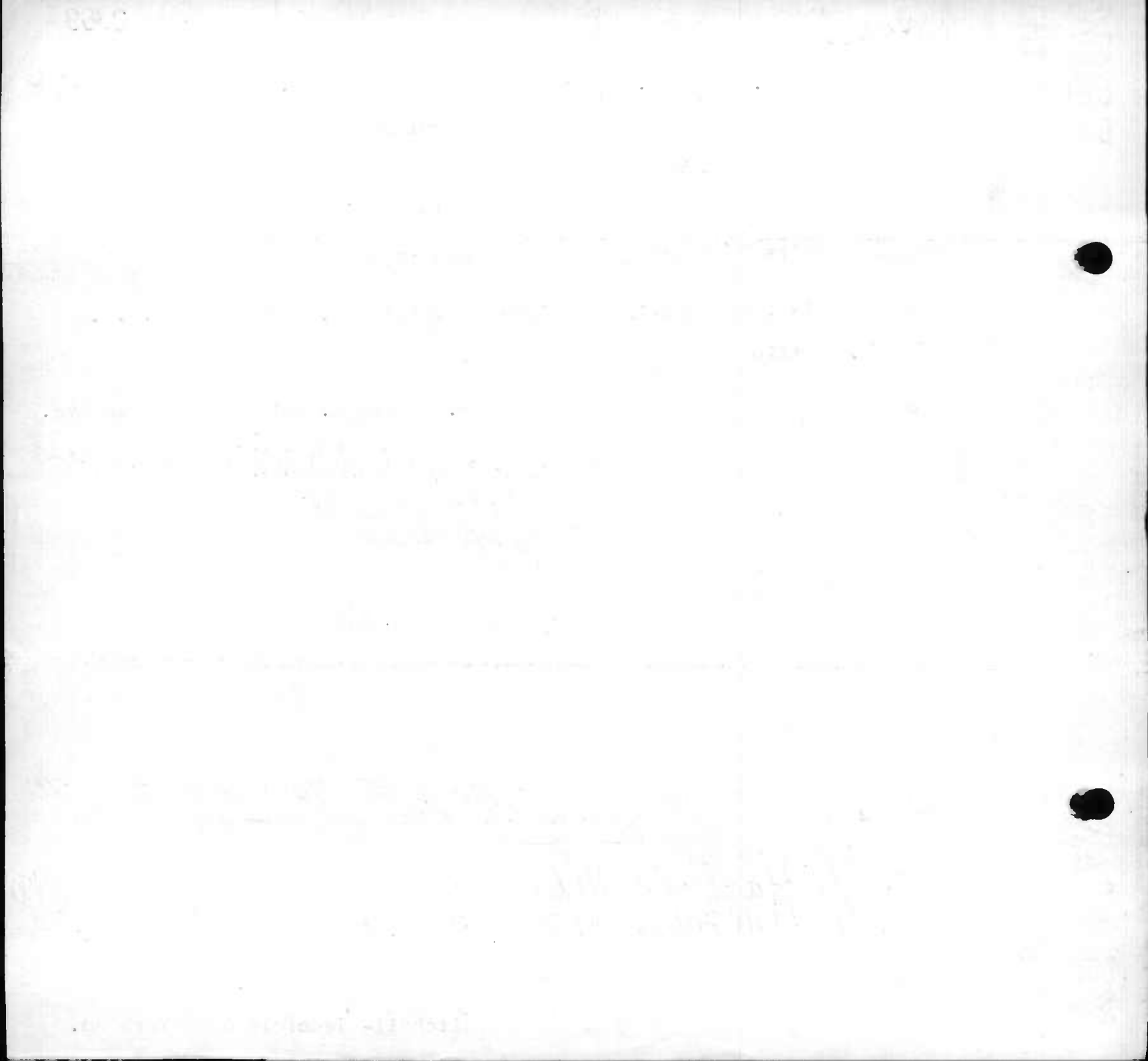
D-454		A-536		70 6668		BALTIMORE CITY HEALTH DEPARTMENT		70 6668	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		Sr. MARY ANDREWS RSM DOWLING		2. DATE AND HOUR OF DEATH 6/23/70 2-23-70		REG. NO. 4-40 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				37 MERCY HOSPITAL, BALTIMORE, Md		Baltimore		301 St. Paul Place	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 28, 1892		9. AGE (in years) lost birthday 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Religious Sister of Mercy						Johnstown, Penna			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Patrick F. Dowling				Mary Mitchel					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Sr. M. Edith RSM Long Crandon			
						ADDRESS Timonium Md			
18. 43371 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF:					
				(B) Arteriosclerotic heart cerebrovascular dis DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-10-1970 to 6-23-1970 that (I) (we) last saw the deceased alive on 6-22-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE C. J. Lomas, MD				23B. DATE SIGNED 6-23-70					
23C. PHYSICIAN'S NAME (Type) CONSTANTINOS J. LOMAS, MD				23D. ADDRESS Mercy Hospital, Baltimore, Md					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		6/25/70		Mt. St. Agnes Cemetery		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Barber, MD		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld		ADDRESS 6500 York Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

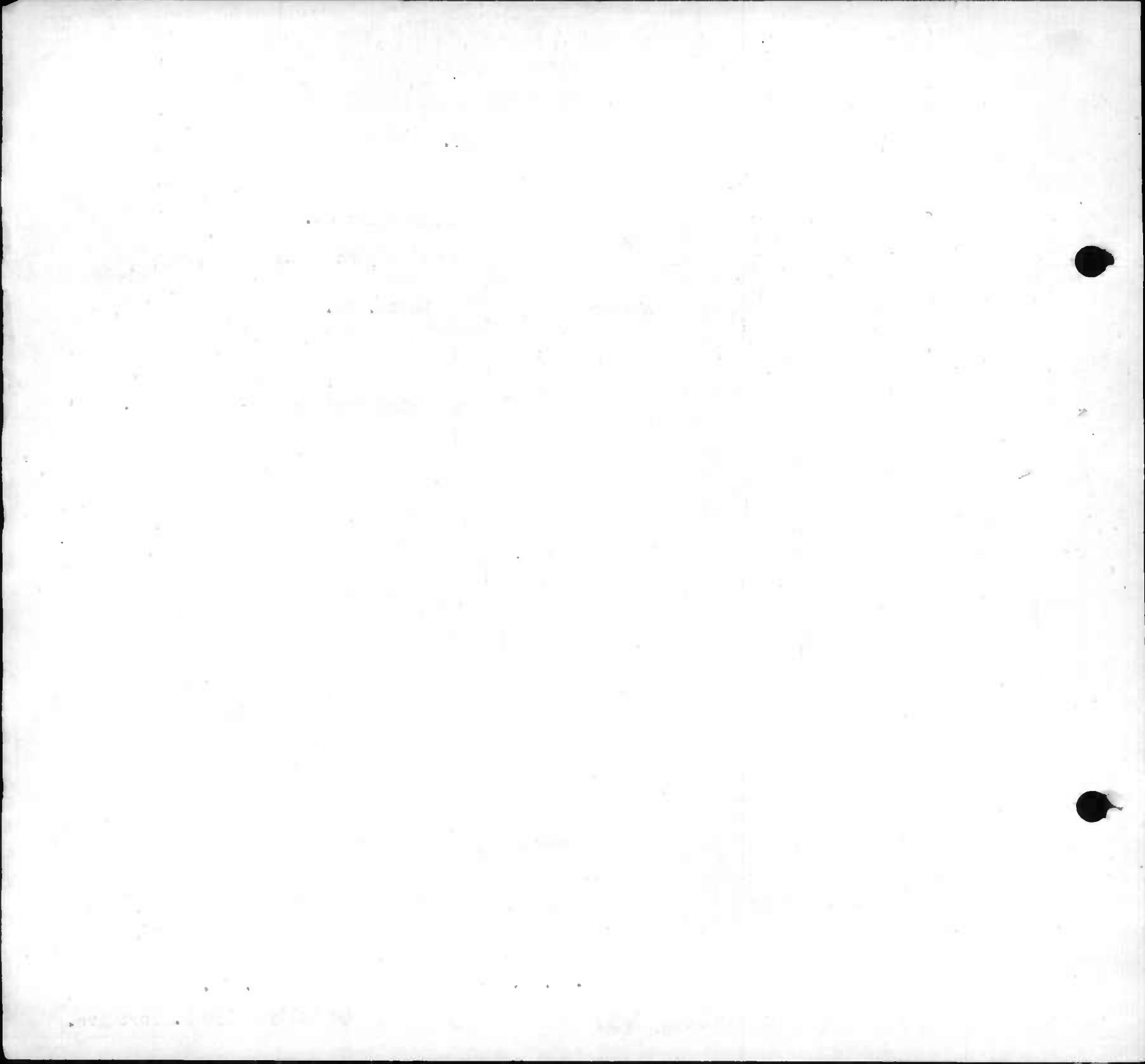
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6669	
BIRTH NO. <u>1-450</u> 70 6669		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mrs. Clara E. Jelks		2. DATE AND HOUR OF DEATH June 21, 1970 5:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 316 Dunkirk Road			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1883 87	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Saleslady		10B. KIND OF BUSINESS OR INDUSTRY Hutzler Brothers		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Louis Chaillou		14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Edward A. Jelks 202 Linden Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 183.01 Abdominal lymphatic Metastatic Carcinoma of ovary Carcinoma of ovary Lymphedema		CAUSE OF DEATH DUE TO, OR AS A CONSEQUENCE OF: (A)..... (B)..... (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 15 1970 to June 21 1970 , that (I) (we) last saw the deceased alive on June 20 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. V. Harbold M.D.		23B. DATE SIGNED June 22, 1970		23C. PHYSICIAN'S NAME (Type) H. V. HARBOLD M.D.	
23D. ADDRESS 4706 Harford Road Baltimore Md 21214		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE June 24		24C. NAME OF CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 1 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld 6500 York Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

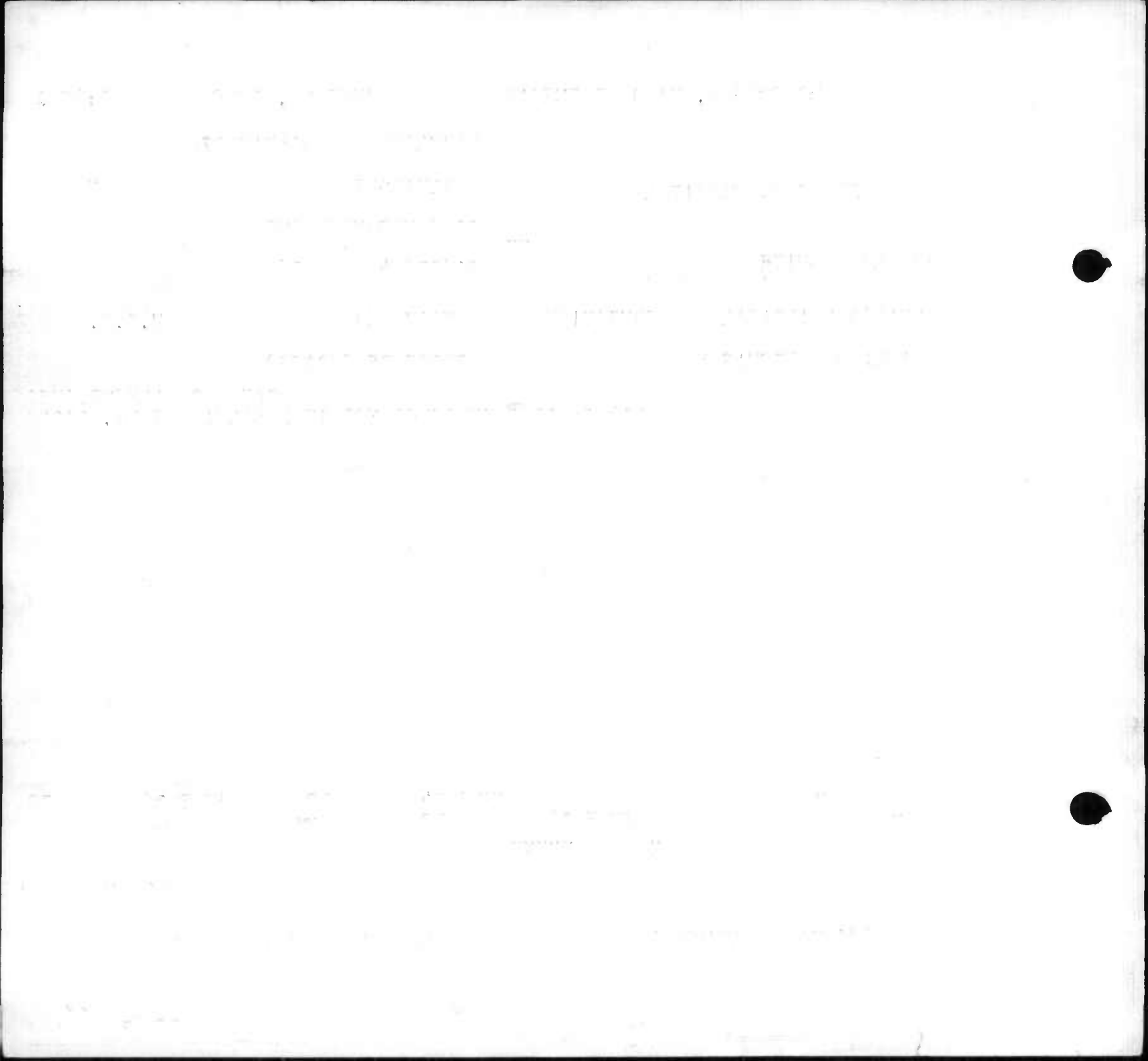
BALTIMORE CITY HEALTH DEPARTMENT				70 6670	
W-300 70 6670				REG. NO. 70 6670	
BIRTH NO. 70 6670				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) WADE, GEORGE FRANCIS			2. DATE AND HOUR OF DEATH 6-30-70 2:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital 3001 S. Hanover Street			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Bl. MD C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1729 Olive St.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-1908	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore, City Highway Dept. Laborer			11. BIRTHPLACE (State or foreign country) Balto. Md.		
13. FATHER'S NAME Charles FRANCIS WADE			14. MOTHER'S MAIDEN NAME Annie E. (LaMar)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Helen Sowards			ADDRESS 1729 Olive St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 3-8-2X1			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (bleed) (B) hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) possible renal & chronic		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). diverticulitis		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-22 19 70 to 6-30 19 70 , that (I) (we) last saw the deceased alive on 6-30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Nabil Yacoub Younan				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) NABIL YACOOB YOUNAN				23D. ADDRESS South Baltimore General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 3 70		24C. NAME OF CEMETERY or CREMATORY Balto. U. S. National	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970			
25B. NAME OF REGISTRAR Robert E. Kelly		25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

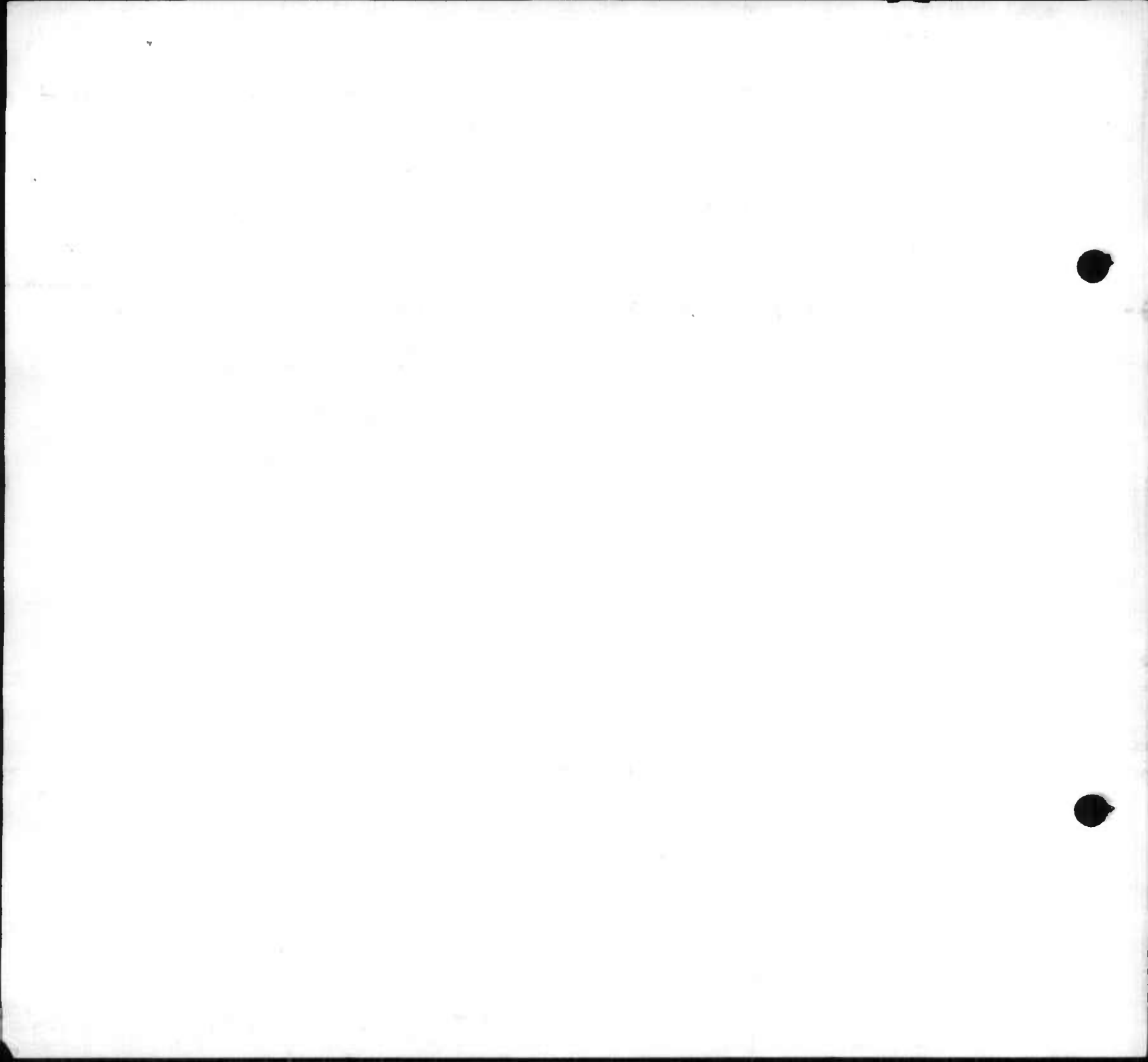
BIRTH NO. M-225 70 6671		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6671	
1. NAME OF DECEASED (Type or Print) MC GUIGAN, HILDA CATHERINE			2. DATE AND HOUR OF DEATH JUNE 28, 1970 3:40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1100 MAGRUDER AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01/07/94	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PRINCIPAL		10B. KIND OF BUSINESS OR INDUSTRY EDUCATION		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM W MCGUIGAN			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 214 38 2787		
17. INFORMANT CATON & WILKENS AVES			ADDRESS ST AGNES HOSPITAL BALTIMORE MD. 21229		
18. CAUSE OF DEATH 398X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last			(A) IMMEDIATE CAUSE Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF: (B) Pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF: (C) Rheumatic Heart disease CHF #20100		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 week					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 24 19 70 to JUNE 28 19 70 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JUNE 28 19 70 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE Bizhan Ebrahimi			23B. DATE SIGNED 06/28/70		23C. PHYSICIAN'S NAME (Type) BIZHAN EBRAHIMI MD
23D. ADDRESS ST AGNES HOSP BALTO MD 21229			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7-1-70			24C. NAME OF CEMETERY OR CREMATORY Linden Park Cem.		
24D. LOCATION (City, town, or county) (State) Baltimore Md.			25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		
25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Harley Cavanaugh		
25D. ADDRESS Cathedral Hill					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

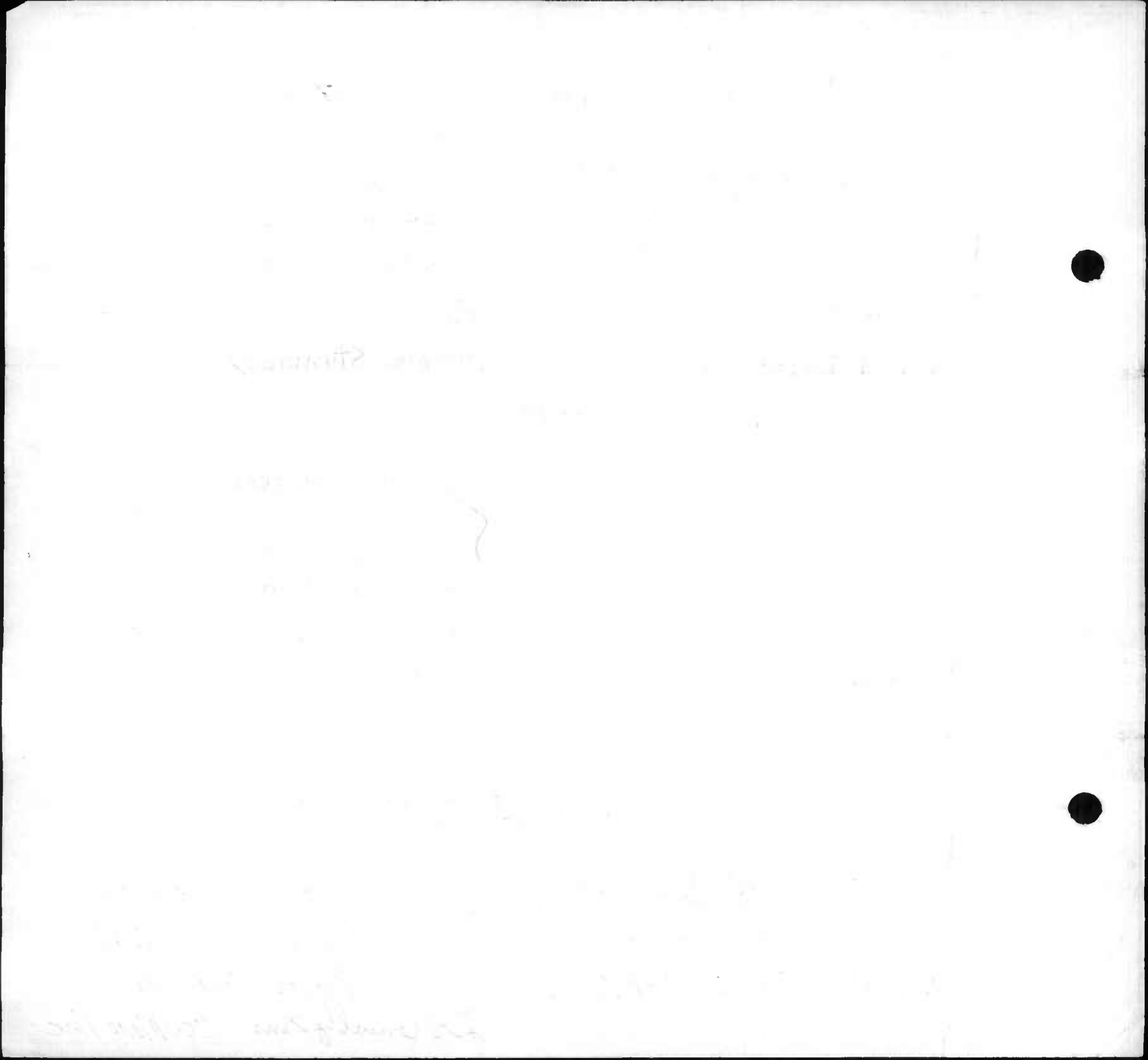
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.	
A-160		70 6672		70 6672	
1. NAME OF DECEASED (Type or Print) FRANK L. HOOPER			2. DATE AND HOUR OF DEATH JUNE 26, 1970 11:35 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6709 Windsor Mill Rd. 21207		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/24/62		9. AGE (In years last birthday) 68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN			10B. KIND OF BUSINESS OR INDUSTRY AUTO.		11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME FRANK L. Hooper		
14. MOTHER'S MAIDEN NAME Mary Fenton			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 215-10-487			17. INFORMANT pts. Chart		
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Acute cardiopulmonary failure Antecedent Causes PT Pneumonia CA lung			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 16-25-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA lung		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-12 1970 to 6-25 1970 that (I) (we) last saw the deceased alive on 6-25 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lucas Vidhyapathum M.D.			23B. DATE SIGNED 6-26-70		23C. PHYSICIAN'S NAME (Type) LUCAS VIDHYAPATHUM M.D.
23D. ADDRESS Bon Secours Hospital			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 6-30-70			24C. NAME OF CEMETERY or CREMATORY Landon Park Cem.		
24D. LOCATION (City, town, or county) (State) Baltimore Md.			25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.			25C. FUNERAL DIRECTOR Farley - Cranney & F. Catonville, Inc.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

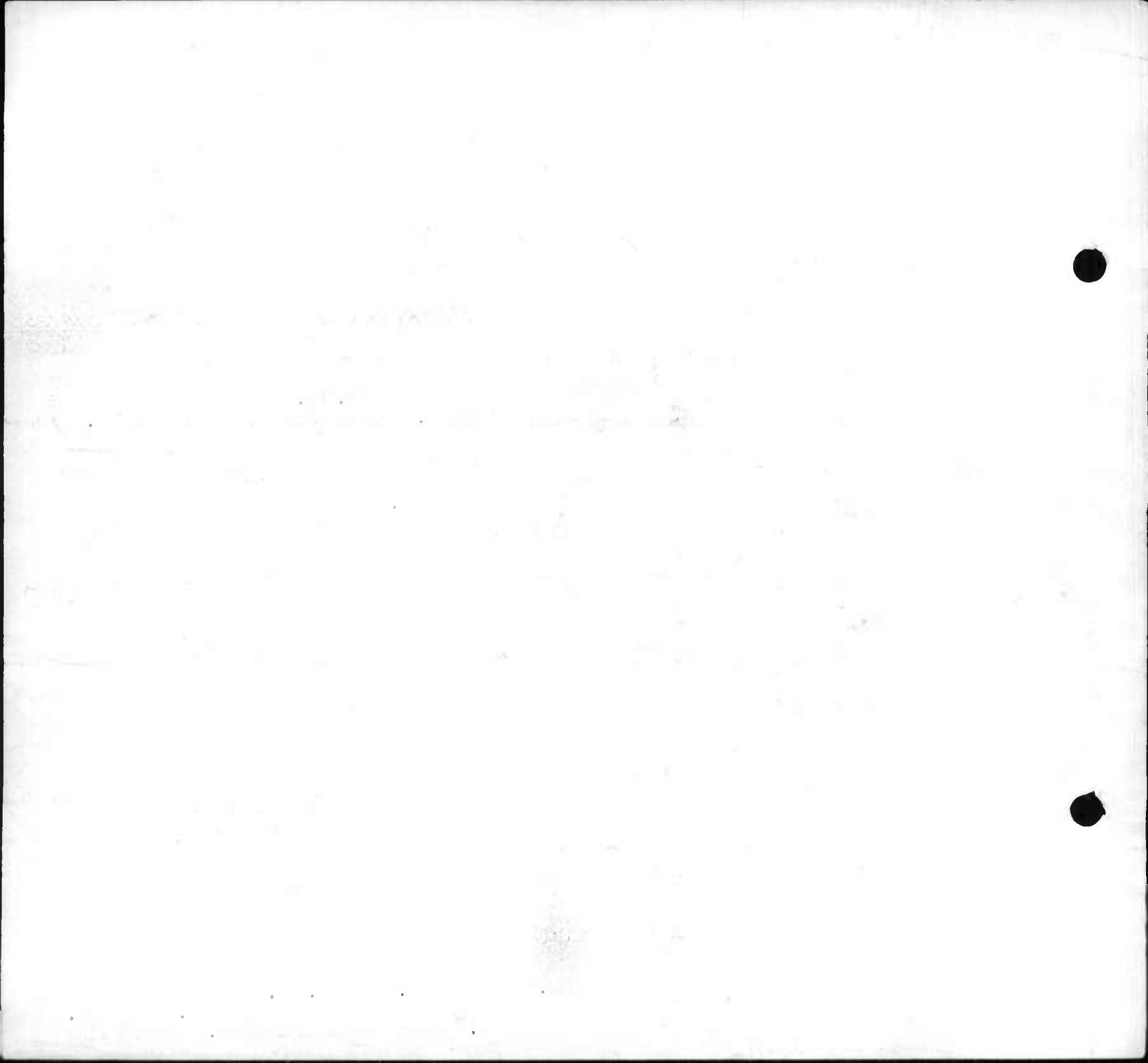
B-600 70 6673		BALTIMORE CITY HEALTH DEPARTMENT		X		70 6673	
BIRTH NO.		70 6673		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Lester W. Boyer</u>				2. DATE AND HOUR OF DEATH <u>6/28/70</u> <u>12:20 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u> <u>3601 N. Broadway</u> <u>Baltimore, Md. 21205</u>				A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>724 Riverside Dr.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/8/11</u>		9. AGE (in years last birthday) <u>59</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem steel</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Stunmetz</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>179-09-9193</u>		17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory arrest</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Respiratory arrest</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>also</u>			
				(C) <u>left colon obstruction</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Metastatic bladder Cancer</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>			
19A. DATE OF OPERATION <u>6/23/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Sigmoid obstruction</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 23, 1970</u> to <u>June 27, 1970</u> and that (I) (we) last saw the deceased alive on <u>June 27, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>David G. Ansel M.D.</u>				23B. DATE SIGNED <u>6/27/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>DAVID G ANSEL M.D.</u>				23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>15/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md 21</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>J. J. Connelly Sons</u>		ADDRESS <u>300 Mace Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

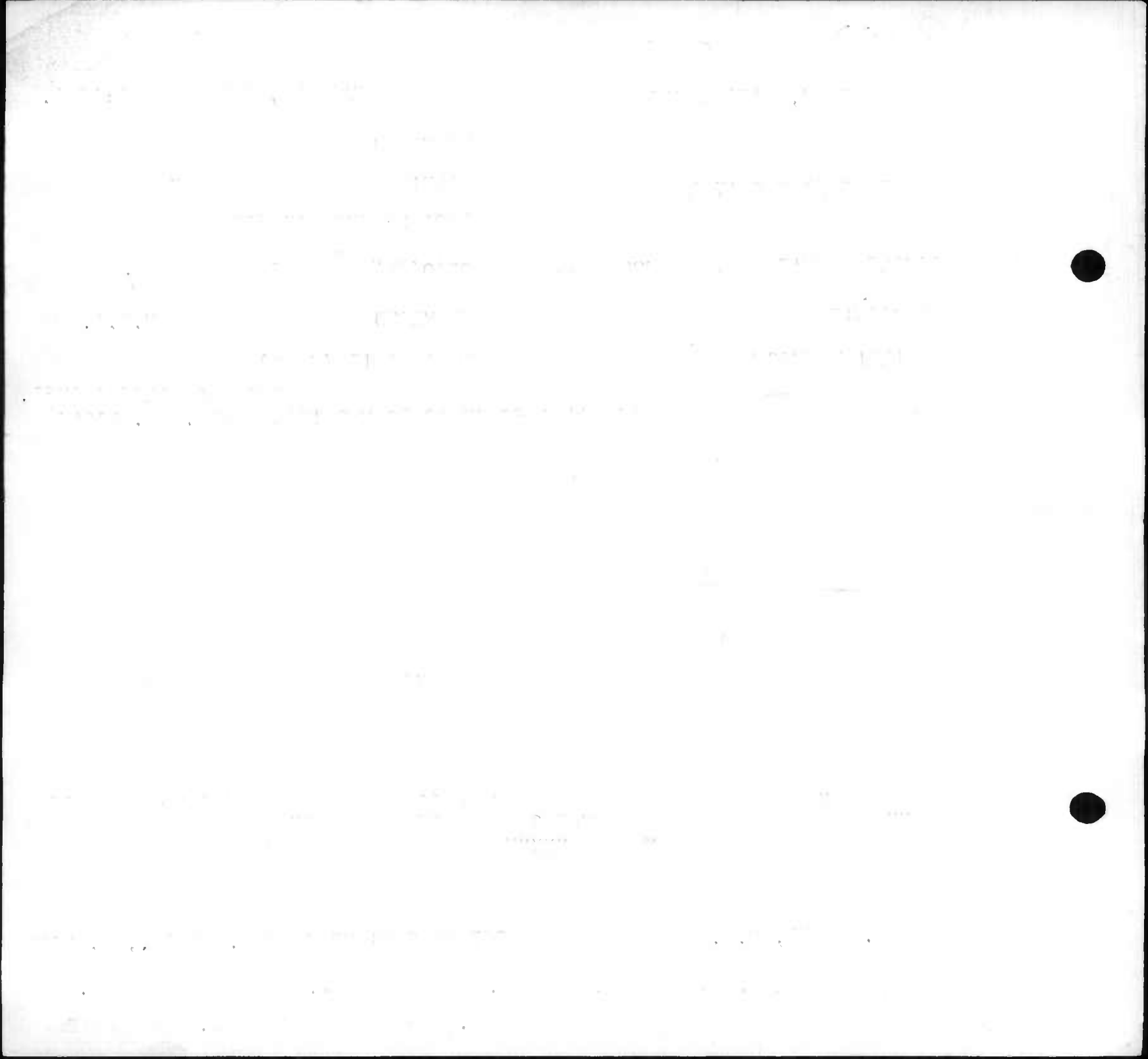
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-420 70 6674		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6674	
BIRTH NO.		1. NAME OF DECEASED <i>Fredricka ESTELLE WALLACE</i>		2. DATE AND HOUR OF DEATH <i>6/27/70 2 P. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>NORTH CHARLES GEN HOSP.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>12-24-14</i>	
13. FATHER'S NAME <i>JOHN BRUAL MANN</i>		14. MOTHER'S MAIDEN NAME <i>SUSIE MASH</i>		9. AGE (In years last birthday) <i>55</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>220-09-2897</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
18. <i>4/12/31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pulmonary Embolism</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Arterio Sclerosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Heart Disease</i> (C) <i>Asthmatic Bronchitis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hours</i> <i>days</i> <i>in years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>6/25</i> 19 <i>70</i> to <i>6/27</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>6/27</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Gracita V. Patricia</i>		23B. DATE SIGNED <i>6/27/70</i>		23C. PHYSICIAN'S NAME (Type) <i>GRACITA V. PATRICIA</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>July 1, 1970</i>		24C. NAME OF CEMETERY or CREMATORY <i>Balto. National Cem.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 2 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Jalen, Jr.</i>		25C. FUNERAL DIRECTOR <i>G. Truman Schwab</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		24E. ADDRESS <i>5151 Balto. National Pike</i>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

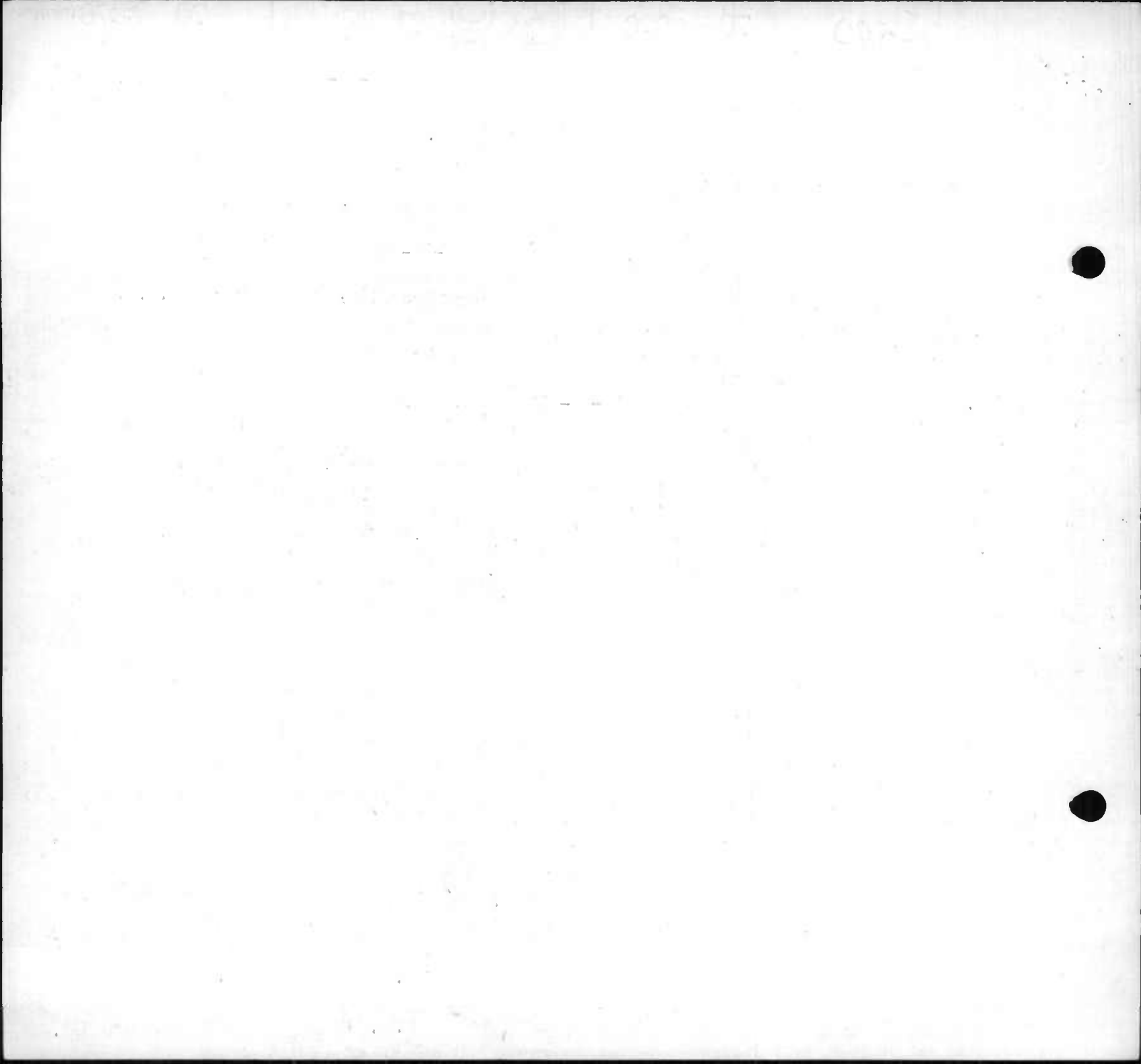
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6675	
G-600 70 6675				CERTIFICATE OF DEATH	
BIRTH NO. 70 6675			1. NAME OF DECEASED (Type or Print) GRAY, RITA LOUISE		
2. DATE AND HOUR OF DEATH JUNE 28, 1970 1:15 A.M.			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2541			5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
6. STREET AND NUMBER 4901 PARKTON STREET Court			7. SEX FEMALE 8. RACE WHITE 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. DATE OF BIRTH 07/06/94 12. AGE (In years last birthday) 75		
13. FATHER'S NAME WILLIAM BUSCH			14. MOTHER'S MAIDEN NAME ANNA MARIE (KERN)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 218 44 3655		
17. INFORMANT CATON & WILKENS AVES.			18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple Pulmonary Embolism, ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary infarction		
19. DATE OF OPERATION 2			20. AUTOPSY? (Yes or No) YES		
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
23. DATE OF OPERATION JUNE 17 19 70			24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
27. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			28. HOW DID INJURY OCCUR?		
29. I certify that (X) (this hospital) attended the deceased from JUNE 17 19 70 to JUNE 28 19 70			30. I certify that (X) (we) last saw the deceased alive on JUNE 28 19 70 and that (X) (we) saw the body after death.		
31. SIGNATURE J. Shams, M.D.			32. DATE SIGNED 6-28-70		
33. PHYSICIAN'S NAME (Type) A. SHAMS, M.D.			34. ADDRESS CATONS & WILKENS AVES. BALTO., MD. 21229		
35. BURIAL CREMATION, REMOVAL (Specify) Burial			36. DATE July 1, 1970		
37. NAME OF CEMETERY or CREMATORY Lorraine Park Cem.			38. LOCATION (City, town, or county) (State) Balto. Md.		
39. DATE REC'D BY HEALTH DEPT. JUL 2 1970			40. NAME OF REGISTRAR Robert E. Taber, R.D.		
41. FUNERAL DIRECTOR G. Truman Schwab			42. ADDRESS 5151 Balto. National Pike		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

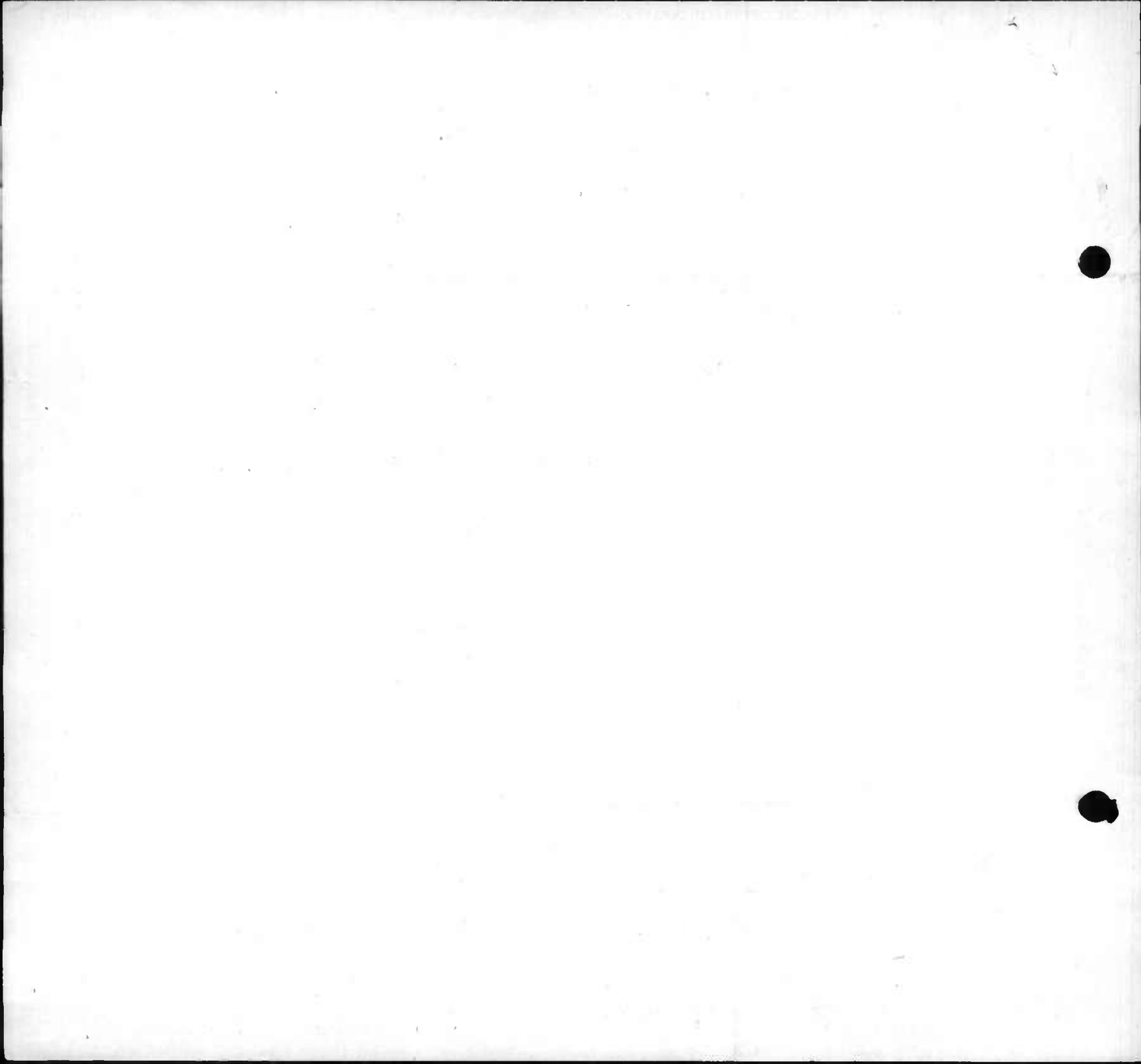
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6676
70 6676		CERTIFICATE OF DEATH		
BIRTH NO. T-520				
1. NAME OF DECEASED (Type or Print) JULIA THOMAS		2. DATE AND HOUR OF DEATH 6-27-70		II:45AM
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BOLTON HILL NURSING CENTER		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2749 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2801 Fleetwood A venue		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-89	9. AGE (In years lost) 80 day
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Staffordville, New Jersey
13. FATHER'S NAME George Edgar Johnson		14. MOTHER'S MAIDEN NAME Ralla Smith Farrow		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-01-0318		17. INFORMANT ADMISSION RECORD
18. 41231 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral thrombosis with paralysis left (B) arteriosclerotic heart disease (C) arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/23/70 yes yes
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 6/12/70 to 6/27 19 70 , that (I) (we) last saw the deceased alive on 6/27 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE a. M. M. M.		23B. DATE SIGNED 6/29/70		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) ALAN H. MACHT MD		23D. ADDRESS 2 E. Resler Blvd Baltimore		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/30/70		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.
24D. LOCATION (City, town, or county) (State) Balto Co.				
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR P.A. Heemann
		ADDRESS 6067 Harford Rd.		



FUNERAL DIRECTOR: IMPORTANT

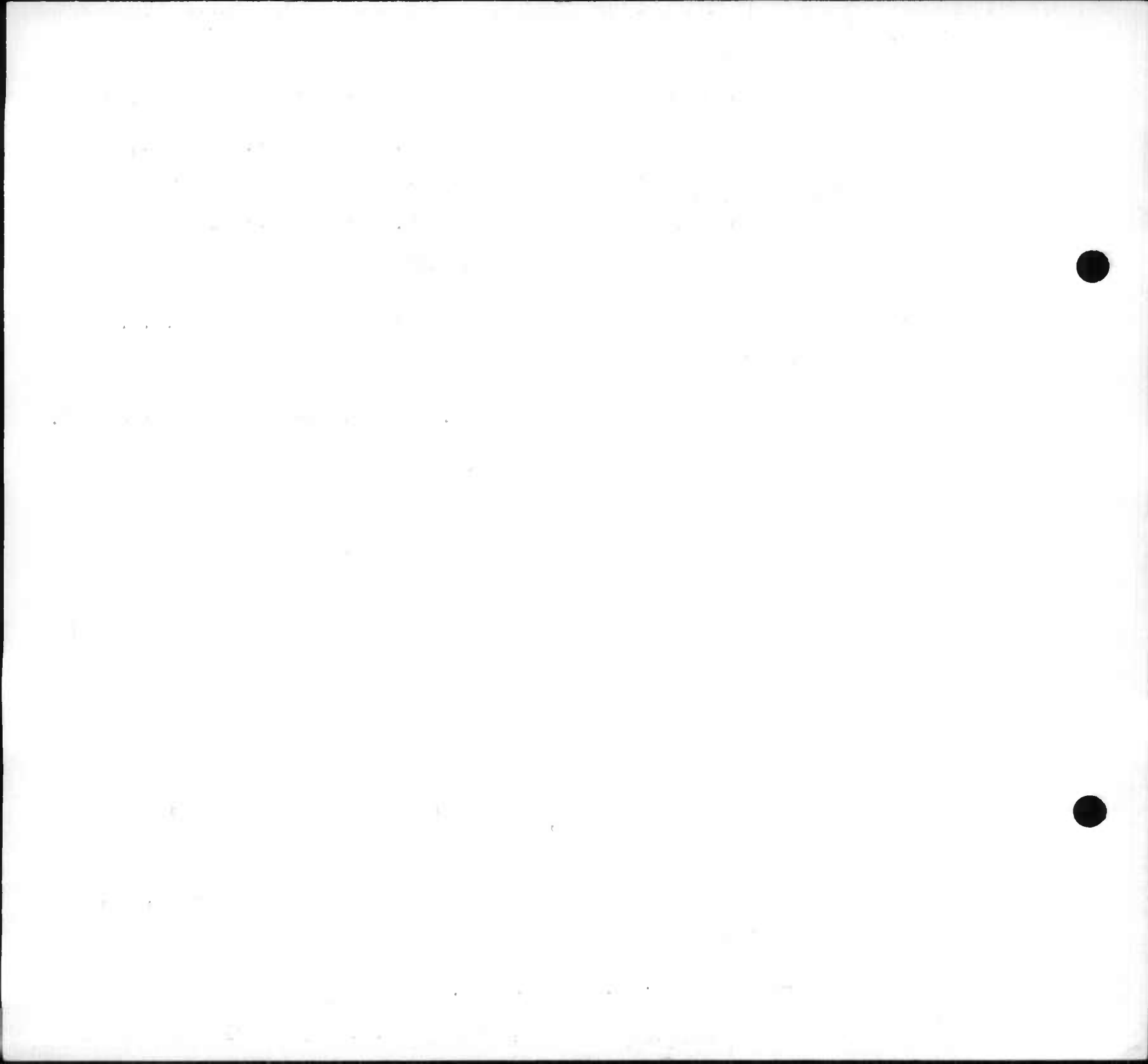
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6677	
L-512 70 6677		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) John P. Leimbach			2. DATE AND HOUR OF DEATH June 24, 1970 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hosp.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2733		
5. SEX M		6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/95	9. AGE (In years last birthday) 75 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cost Estimator		10B. KIND OF BUSINESS OR INDUSTRY Bndix		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Peter J.			14. MOTHER'S MAIDEN NAME Caroline Erbst		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-10-6806A		17. INFORMANT Marie Leimbach	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ACUTE CORONARY OCCLUSION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C.V. Dis. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 year 6 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 8, 1964 to June 24, 1970, that (I) (we) last saw the deceased alive on June 24, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. J. Sawyer Jr. M.D.				23B. DATE SIGNED 6/26/70	
23C. PHYSICIAN'S NAME (Type) G. J. SAWYER JR. M.D.				23D. ADDRESS 4808 Harford Rd, Balto Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/28/70		24C. NAME OF CEMETERY or CREMATORY Immanuel	
24D. LOCATION (City, town, or county) (State) Grindon Lane Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970			
25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR P. A. Heemann 6067 Harford Rd.			



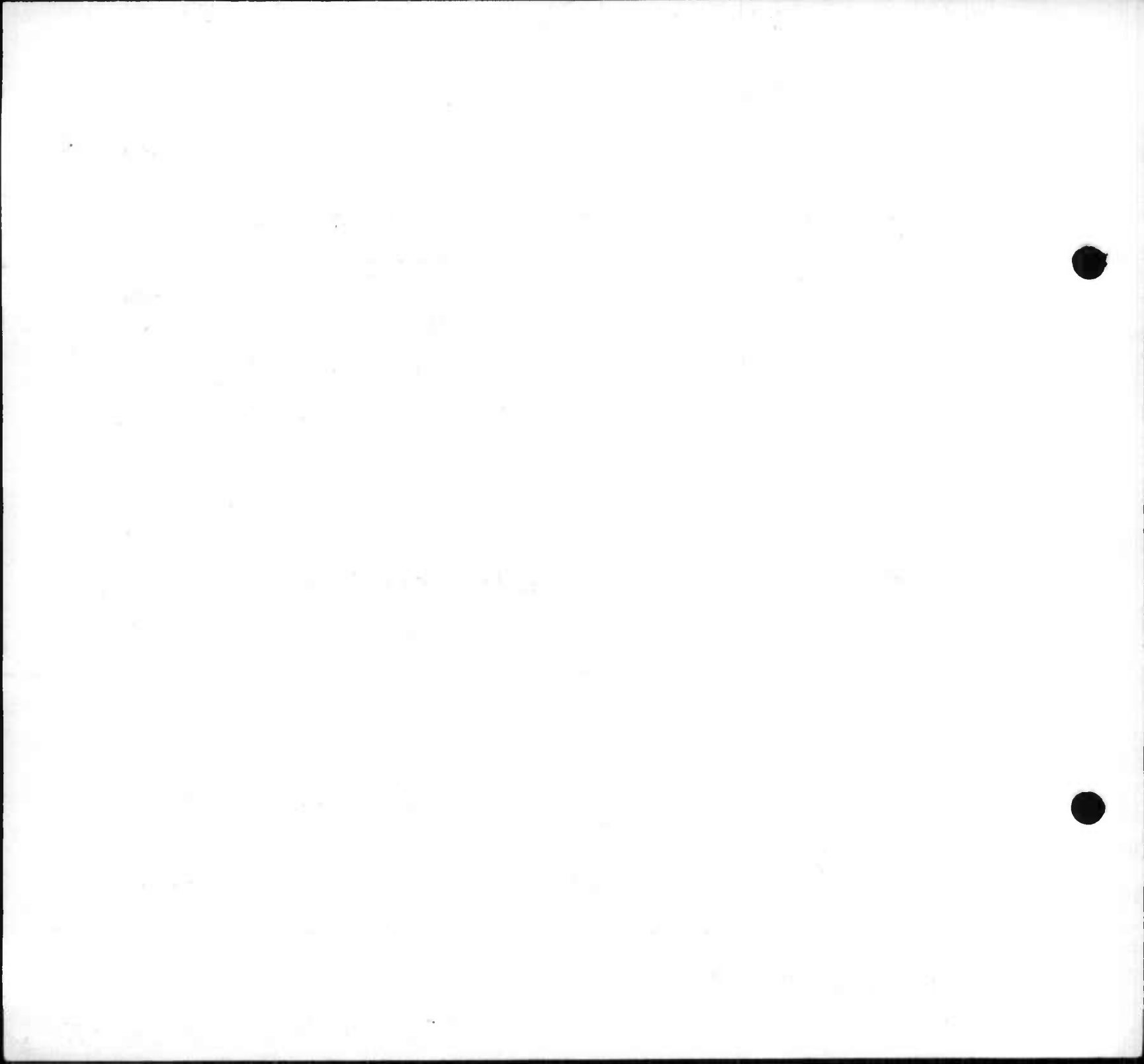
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6678</u>	
BIRTH NO. <u>B-412 70 6678</u>					
1. NAME OF DECEASED (Type or Print) <u>Billups, Alexander</u>			2. DATE AND HOUR OF DEATH <u>6-29-70</u> <u>8:40</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39 Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY <u>1152 N. Stricker St. Balto., Maryland</u> C. CITY OR TOWN D. INSIDE CITY LIMITS? <u>Baltimore</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1152 N. Stricker Street</u> <u>1602</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-21</u>	9. AGE (In years last birthday) <u>49</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Billups</u>			14. MOTHER'S MAIDEN NAME <u>Eva Walker</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>12/29/42*1/6/46</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Mary Manning 1152 Stricker St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Central Thrombosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>23 days</u>		
19A. DATE OF OPERATION <u>6-29-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>June 29, 1970</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1970</u> to <u>June 29, 1970</u> that (I) (we) last saw the deceased alive on <u>June 29, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Roland T. Smoot</u>			23B. DATE SIGNED <u>June 30, 1970</u>		
23C. PHYSICIAN'S NAME (Type) <u>ROLAND T. SMOOT</u>			23D. ADDRESS <u>Provident Hospital, Balto. 17, Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-3-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Balto. Nat'l. Cem.</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Bailey, Jr.</u>		25C. FUNERAL DIRECTOR <u>Kelson F.H. 1348 Calhoun Street</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1		D-520 70 6679		BALTIMORE CITY HEALTH DEPARTMENT		70 6679	
CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Celeste Downs</u>		2. DATE AND HOUR OF DEATH <u>6-28-70</u>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>1509</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3911 Fairview Ave.</u>							
5. SEX <u>Female</u>	6. RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-88</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>General Roy</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Washington</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-58-48287</u>		17. INFORMANT <u>Annie M. Simms - same</u>		ADDRESS	
18. <u>412.417230.9</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary Edema</u>		<u>1 hr</u>	
ANTECEDENT CAUSES				(B) <u>Arteriosclerotic Cardiovascular disease</u>		<u>10 yrs</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <u>Diabetes</u> <u>old age</u>		<u>20 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes mellitus</u>				<u>10 yrs</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/8 1969</u> to <u>6/26 1970</u> that (I) (we) last saw the deceased alive on <u>6/4 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Edward O. Hunt, Jr.</u>				23B. DATE SIGNED <u>6/30/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Edward O. Hunt, Jr., M.D.</u>	
23D. ADDRESS <u>2300 Garrison Boulevard Balto., Md. 21216</u>				23E. FUNERAL DIRECTOR <u>U. BAILEY</u>		ADDRESS <u>KELSON F.H. 1348 CALHOUN ST.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-1-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>U. BAILEY</u>		ADDRESS <u>KELSON F.H. 1348 CALHOUN ST.</u>	



C-160

70

6680

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

6680

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIE J. COOPER

2. DATE

Known ☐

Month

Day

Year

Hour

DEATH

Estimated ☐

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 3727 Overview Rd.

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

6

30

1970

10:30A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md.

B. COUNTY

15-12

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2/26/19

10. AGE (In years
lost birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3727 Overview Rd.

11. BIRTHPLACE (State or foreign country)

GEORGIA

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

ALEXANDER COOPER

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LETTER CARRIER

14B. KIND OF BUSINESS OR INDUSTRY

U.S. POST OFFICE

15. MOTHER'S MAIDEN NAME

MINNIE LEE HALL COOPER

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

2/11/44 5/5/46

17. SOCIAL
SECURITY NO.

219 01 6404

18. INFORMANT

ADDRESS

GLORIA COOPER 4810 BELLE AVENUE, BALTO., MD.

19.

571.01

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty liver
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) chronic alcoholism
DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7/3/70

24C. NAME of CEMETERY or CREMATORY

BALTIMORE NATIONAL CEMETERY

24D. LOCATION (City, town, or county) (State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

JUL 2 1970

25B. NAME OF REGISTRAR

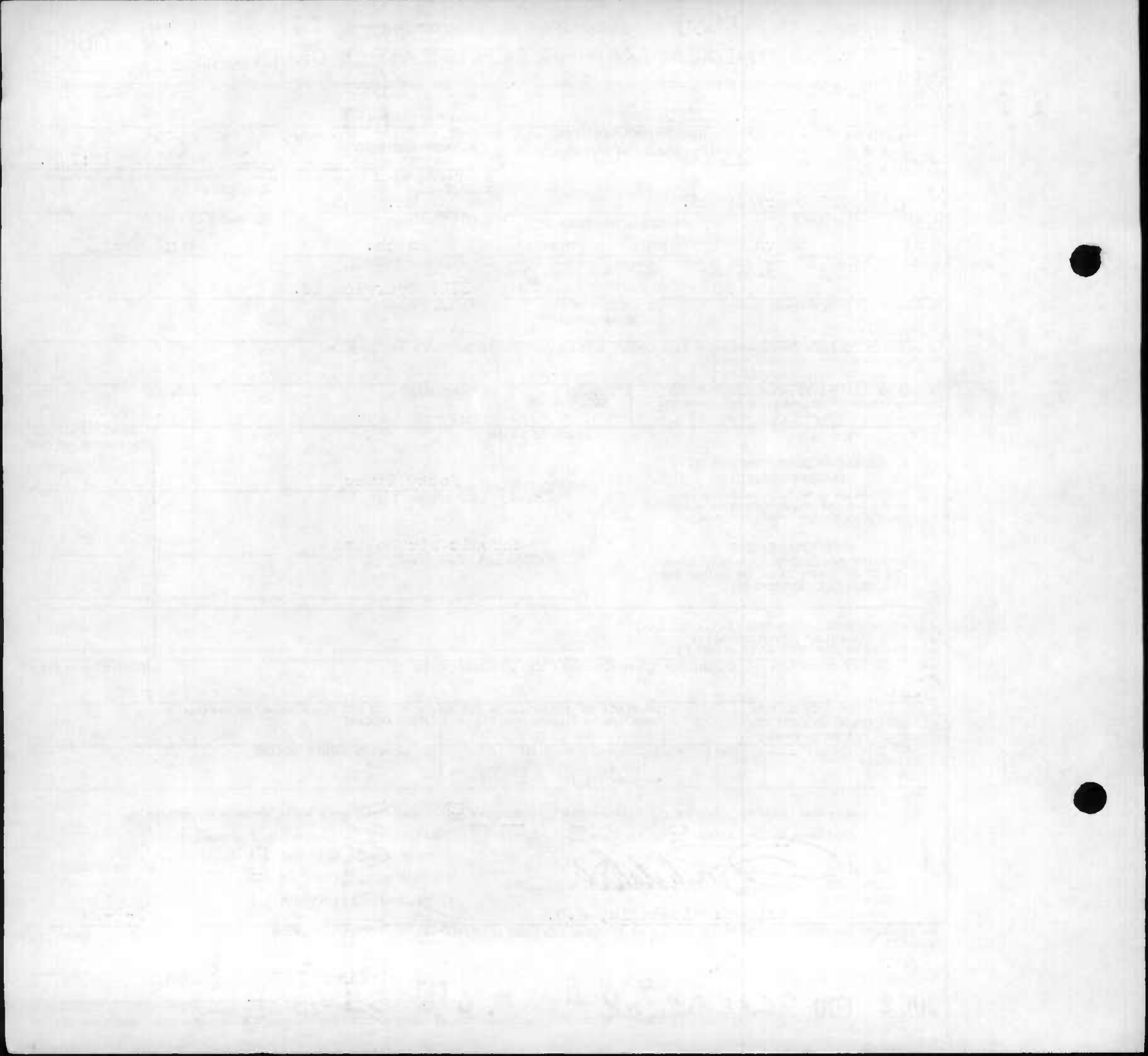
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ORLINGTON S.

ADDRESS

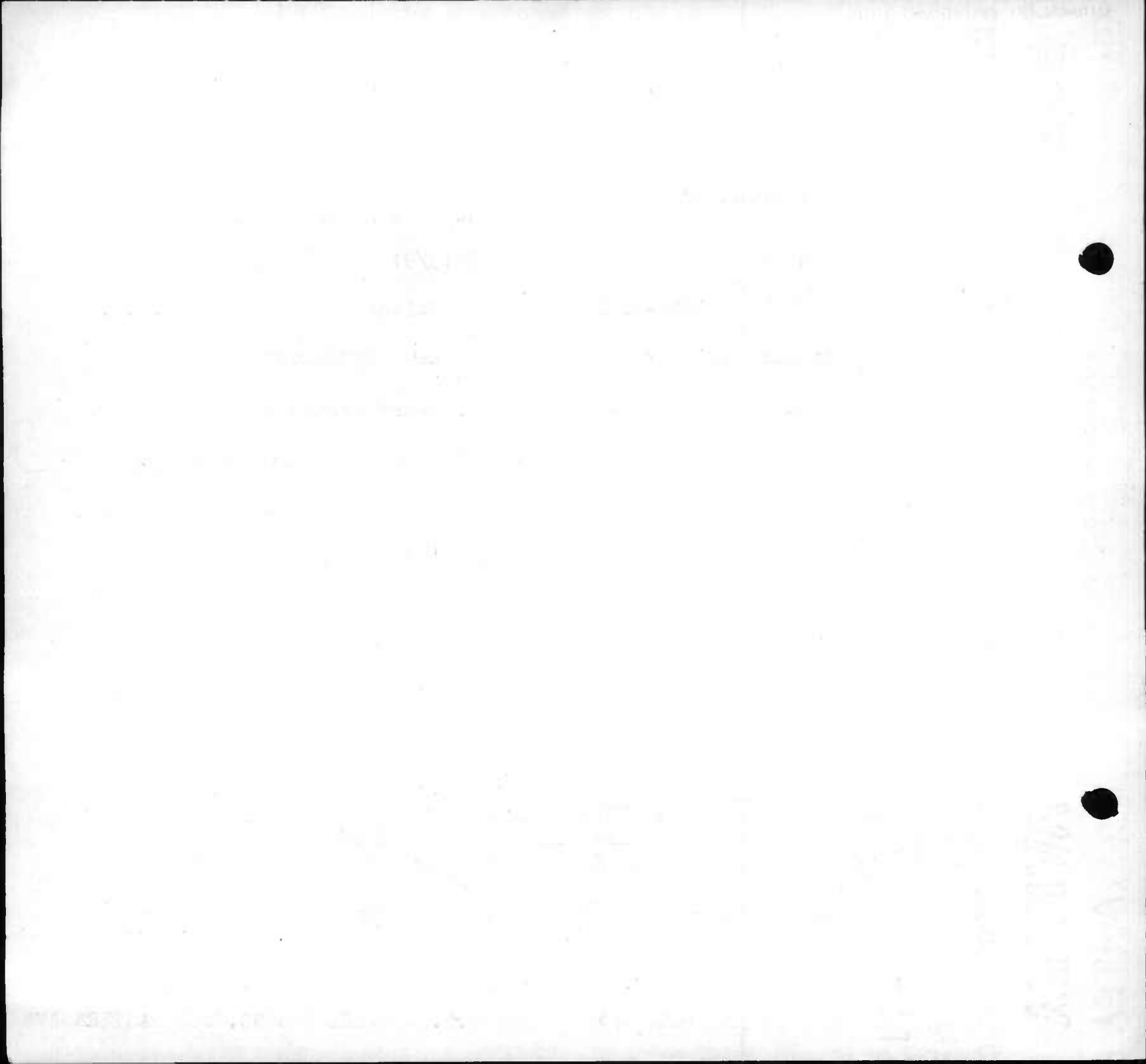
PHILLIPS 1727 N. MONROE STREET



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

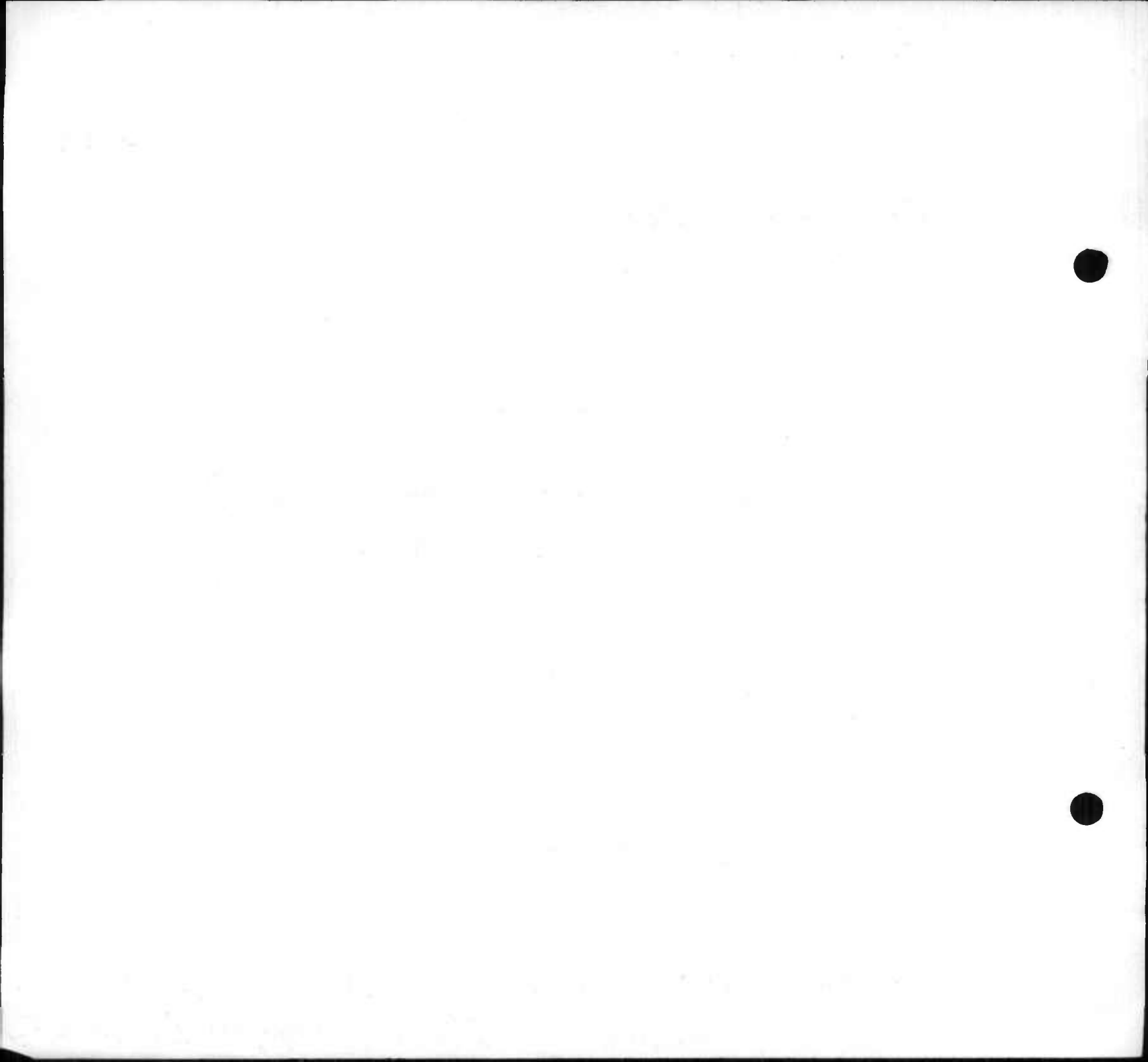
W-422 70 6681				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6681	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOSEPH W. WALCZUK				2. DATE AND HOUR OF DEATH June 30, 1970 6:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4411 Frankford Avenue				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2632 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4411 Frankford Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/13/91		9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10B. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Ignatius Walczuk			
14. MOTHER'S MAIDEN NAME Anna Cymerman				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -			
16. SOCIAL SECURITY NO. 218-32-3658				17. INFORMANT ADDRESS Mr. Edward Walczuk, 4411 Frankford Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 1621 I CAUSE OF DEATH Bronchogenic Carcinoma 15 months (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 months			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 11, 1966 to June 30, 1970 , that (I) (we) last saw the deceased alive on June 22, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE MELVIN F. POLEK				23B. DATE SIGNED July 2, 1970		23C. PHYSICIAN'S NAME (Type) MELVIN F. POLEK	
23D. ADDRESS 3603 BELAIR RD. BALTO. MD.				23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/4/70		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS		25D. ADDRESS 1808 EASTERN AVE	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 70 6682	
<div style="display: flex; justify-content: space-between;"> S-521 70 6682 </div>							
BIRTH NO. 1 1. NAME OF DECEASED (Type or Print) ISABELLE Simkevicius (Shimkus)				2. DATE AND HOUR OF DEATH 7/1/70 8:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="font-size: 1.2em;">34 BON SEECOR HOSPITAL</div>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 1902			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SEECOR HOSPITAL				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/15/1911 9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LITHUANIA	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME PIUS VAITKEVICIUS			
14. MOTHER'S MAIDEN NAME ELIZABETH GOILUNAS				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 220-030754 PT'S CHART				17. INFORMANT ADDRESS			
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> CAUSE OF DEATH I (A) IMMEDIATE CAUSE Renal Carcinoma Rt. DUE TO OR AS A CONSEQUENCE OF: (B) Metastasis both lungs DUE TO OR AS A CONSEQUENCE OF: (C) Arteriosclerosis CV disease </div> <div style="width: 10%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo? 2 mo? </div> </div>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 16-4-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tumor abdomen		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 5-31-1970 to 7-1-1970 that (I) (we) last saw the deceased alive on July 1, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE J. J. Sullivan				23B. DATE SIGNED 7-1-70		23C. PHYSICIAN'S NAME (Type) J. J. Sullivan	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7/2/70		24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	
24D. LOCATION (City, town, or county) (State) BALTO MD				25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970			
25B. NAME OF REGISTRAR Robert E. Johnson				25C. FUNERAL DIRECTOR John J. Kerpner			
25D. ADDRESS 1330 Hollins St				25E. ADDRESS 1330 Hollins St			



S-536

70

6683

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

6683

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE SAUNDERS (SANDERS)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 2, 1970		Hour 3:30 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year July 2, 1970		Hour 3:30 A.M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1512				
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 8-24-25		10. AGE (In years last birthday) 44	11. BIRTHPLACE (State or foreign country) Clayton, North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arthur Griffis		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		15. MOTHER'S MAIDEN NAME Sittie Jane Sanders		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. 240-34-9751		18. INFORMANT Mrs. Lessie Bell
19. 34571-2881X		CAUSE OF DEATH Cerebro-cranial injuries apparently occurring during seizure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:		
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) sidewalk		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3500 Park Heights Avenue
22D. TIME OF INJURY (APPROX.) 6-24-70 9:19 A.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Apparently had seizure and fell on sidewalk striking head
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 2, 1970
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-5-70	24C. NAME of CEMETERY or CREMATORY Family Lot	
24D. LOCATION (City, town, or county) (State) Clayton, North Carolina				
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens Street

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]

DECEASED'S RESIDENCE: [illegible]
DECEASED'S OCCUPATION: [illegible]

DECEASED'S MARITAL STATUS: [illegible]
DECEASED'S RELIGION: [illegible]

DECEASED'S EDUCATION: [illegible]
DECEASED'S SOCIAL STATUS: [illegible]

DECEASED'S HEALTH: [illegible]
DECEASED'S MENTAL STATE: [illegible]

DECEASED'S PHYSICAL STATE: [illegible]
DECEASED'S MENTAL STATE: [illegible]

DECEASED'S PHYSICAL STATE: [illegible]
DECEASED'S MENTAL STATE: [illegible]

DECEASED'S PHYSICAL STATE: [illegible]
DECEASED'S MENTAL STATE: [illegible]

DECEASED'S PHYSICAL STATE: [illegible]
DECEASED'S MENTAL STATE: [illegible]

T-615

70

6684

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70

6684

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE S. TURPIN, Jr.

2. DATE OF DEATH
Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
OR INSTITUTION

00 1902 Bradish Ave.

3. DATE PRONOUNCED DEAD Month Day Year Hour
7 1 1970 5:45 A. M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md. B. COUNTY 1506

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

5-11-30

10. AGE (In years last birthday)

40

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1902 Bradish Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

George Samuel Turpin, Sr.

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bakery

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rosetta Turpin

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

2/25/46 5/12/46

17. SOCIAL SECURITY NO.

219229449

18. INFORMANT

Edith Turpin

ADDRESS

1902 Braddish Avenue

19.

I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S

NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-70

24A. BURIAL CREMATION, REMOVAL (Specify)
Burial

24B. DATE

7-6-70

24C. NAME of CEMETERY or CREMATORY

Balto. Nat'l Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 2 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

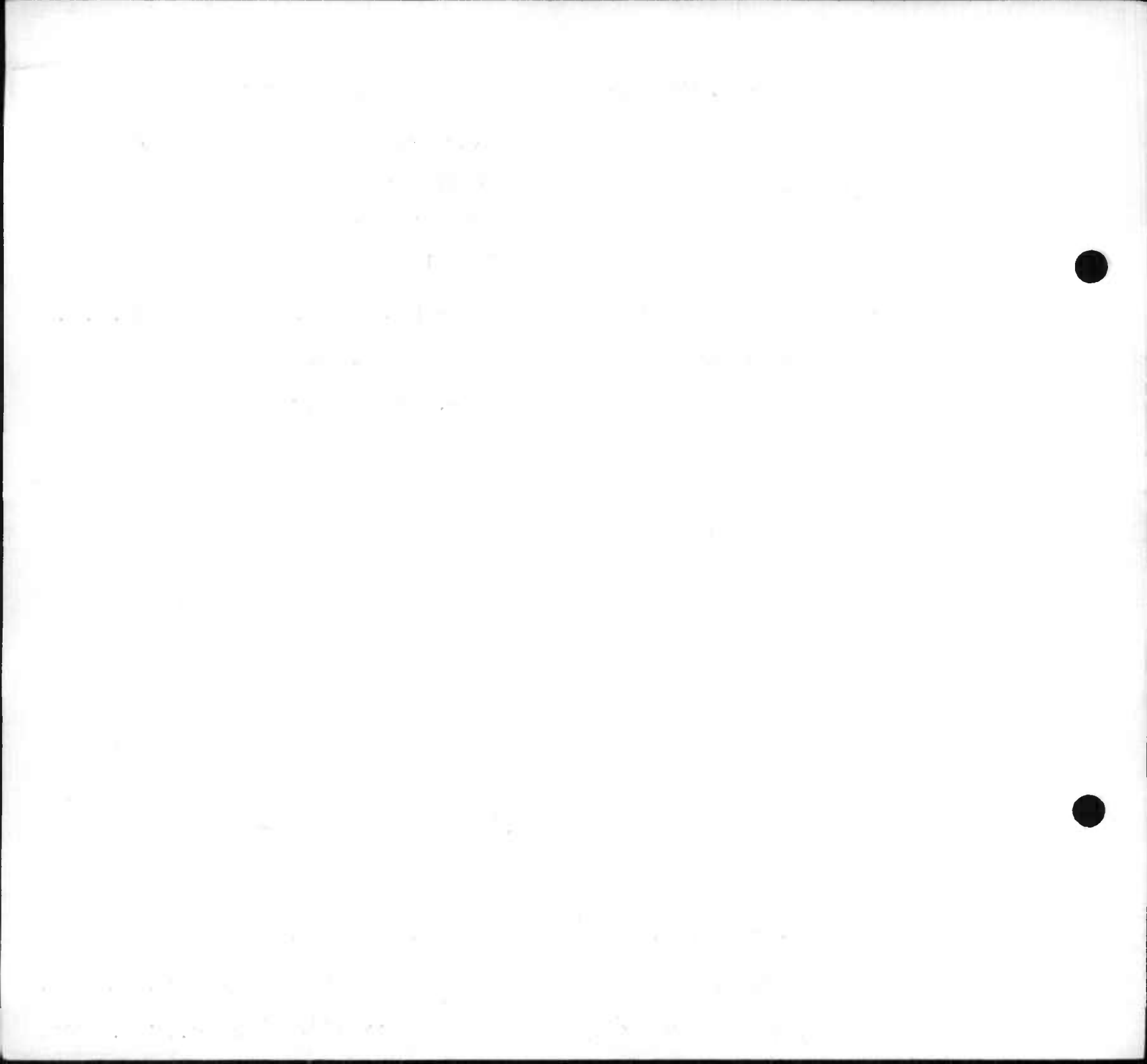
MORTON & DYETT F.H.

ADDRESS

1701 Laurens Street

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6685		REG. NO. 70 6685	
BIRTH NO. <u>H-155</u>				70 6685		70 6685	
1. NAME OF DECEASED (Type or Print) <u>Meta B. Huppman</u>				2. DATE AND HOUR OF DEATH <u>June 30, 1970</u> <u>7:15</u> A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 335 Tunbridge Road</u>				A. STATE <u>Maryland</u> B. COUNTY <u>2712</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>335 Tunbridge Road</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-5-1883</u>	9. AGE (In years last birthday) <u>86</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Worthington Brundige</u>				14. MOTHER'S MAIDEN NAME <u>Mary Brodgdgen</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. David O'Dunne</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Hypertensive Cardiovascular-renal Disease</u> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Hypertensive Cardiovascular-renal Disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs. +</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 27 1970</u> to <u>June 30 1970</u> that (I) (we) last saw the deceased alive on <u>June 28 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert W. Garis, M.D.</u>				23B. DATE SIGNED <u>June 30, 1970</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. Robert W. Garis</u>				23D. ADDRESS <u>12 E. Eager Street</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>8-2-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Henry W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road Balto., Md. 21212</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

6688

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PETER G. POWERS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3203 Evergreen Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 30 1970 12 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2759	
9. DATE OF BIRTH 7/24/1952		10. AGE (In years last birthday) 17	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carroll I. Powers		14. MOTHER'S MAIDEN NAME Joan Reeves	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Joan R. Powers		18. ADDRESS 1230 Northview Rd.	

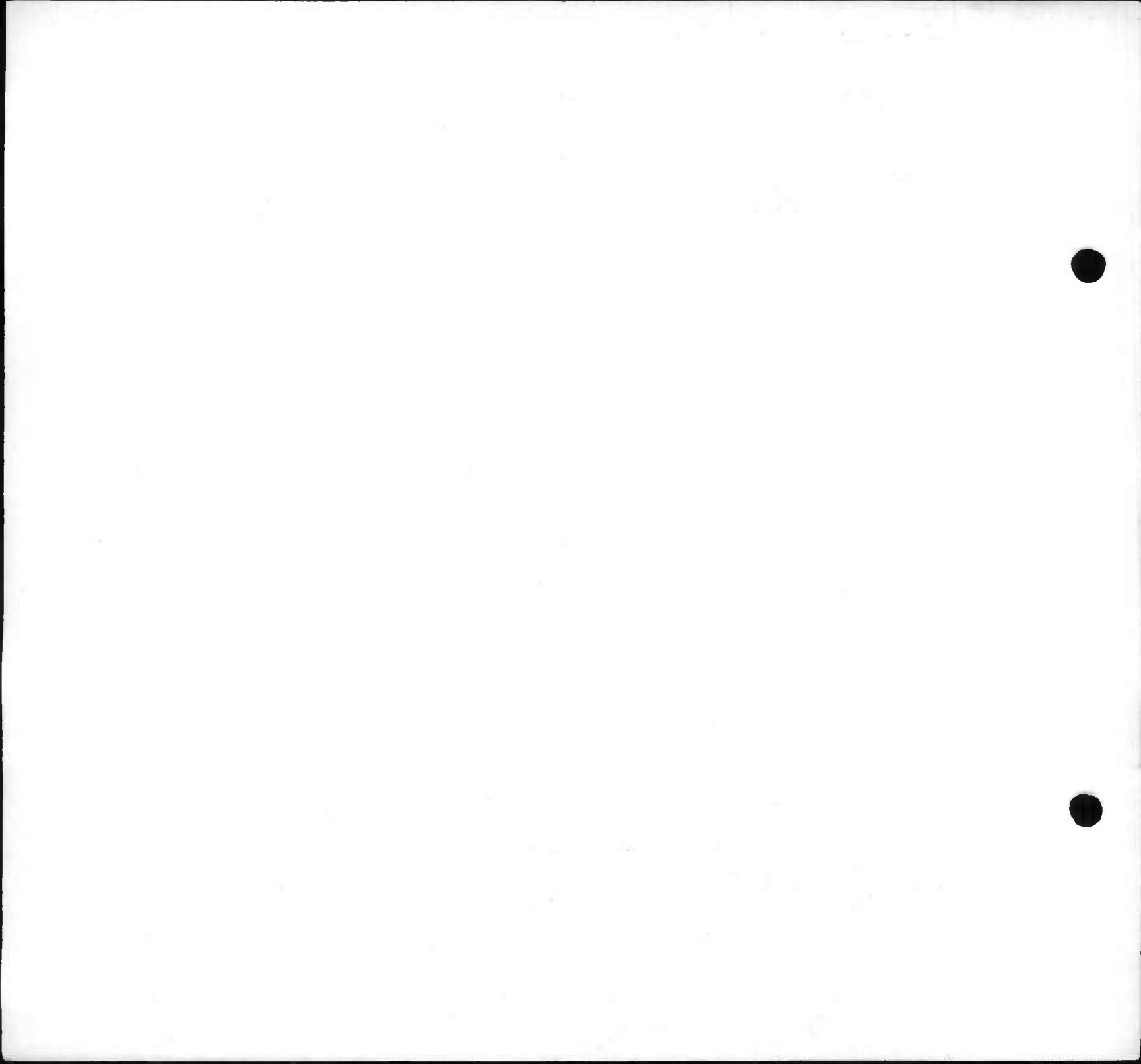
19. CAUSE OF DEATH 304.9		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Intravenous narcotism		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-1-70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/2/70	
24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Grds.		24D. LOCATION (City, town, or county) (State) Timonium, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Jenkins	
25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212	

Letter from M.E.'s office 10-5-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

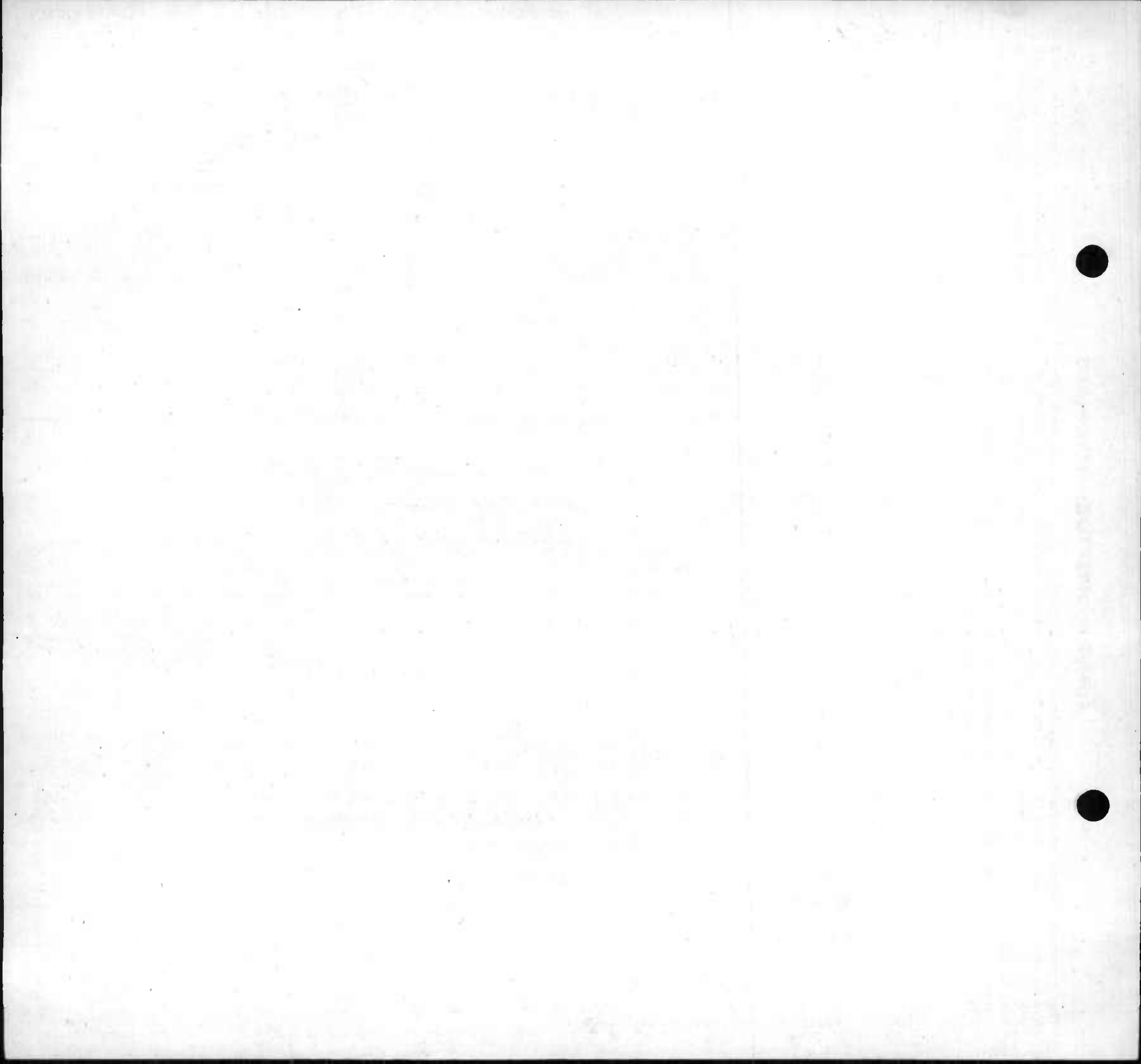
BIRTH NO. 70 6687		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6687	
1. NAME OF DECEASED (Type or Print) GERTRUDE HOLLEY		2. DATE AND HOUR OF DEATH 6-30-70 1 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Montebello State Hosp.		A. STATE MD.		B. COUNTY BALTO.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 Balto.		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1038 W. Franklin St.					
5. SEX F	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 27-1889	9. AGE (in years last birthday) 81	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Ann ?		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 516-18-6345		17. INFORMANT Viola Jackson 823 George St.	
18. 412-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MO.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CEREBRAL THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF:		4 MO.	
		(C) HYPERT. ARTERIOSCL. DISEASE		10+ YES	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-26-70 to 6-30-70 that (I) (we) last saw the deceased alive on 6-30-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Raymond W. Heremann		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-30-70	
23C. PHYSICIAN'S NAME (Type) Raymond W. Heremann		23D. ADDRESS STATE HOSP. MONTEBELLO BALTO MD			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-6-70		24C. NAME OF CEMETERY or CREMATORY Quintus Cent.	
24D. LOCATION (City, town, or county) BALTO		24E. LOCATION (State) MD			
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR E. D. Wilson	
				ADDRESS 1038 W. Franklin St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

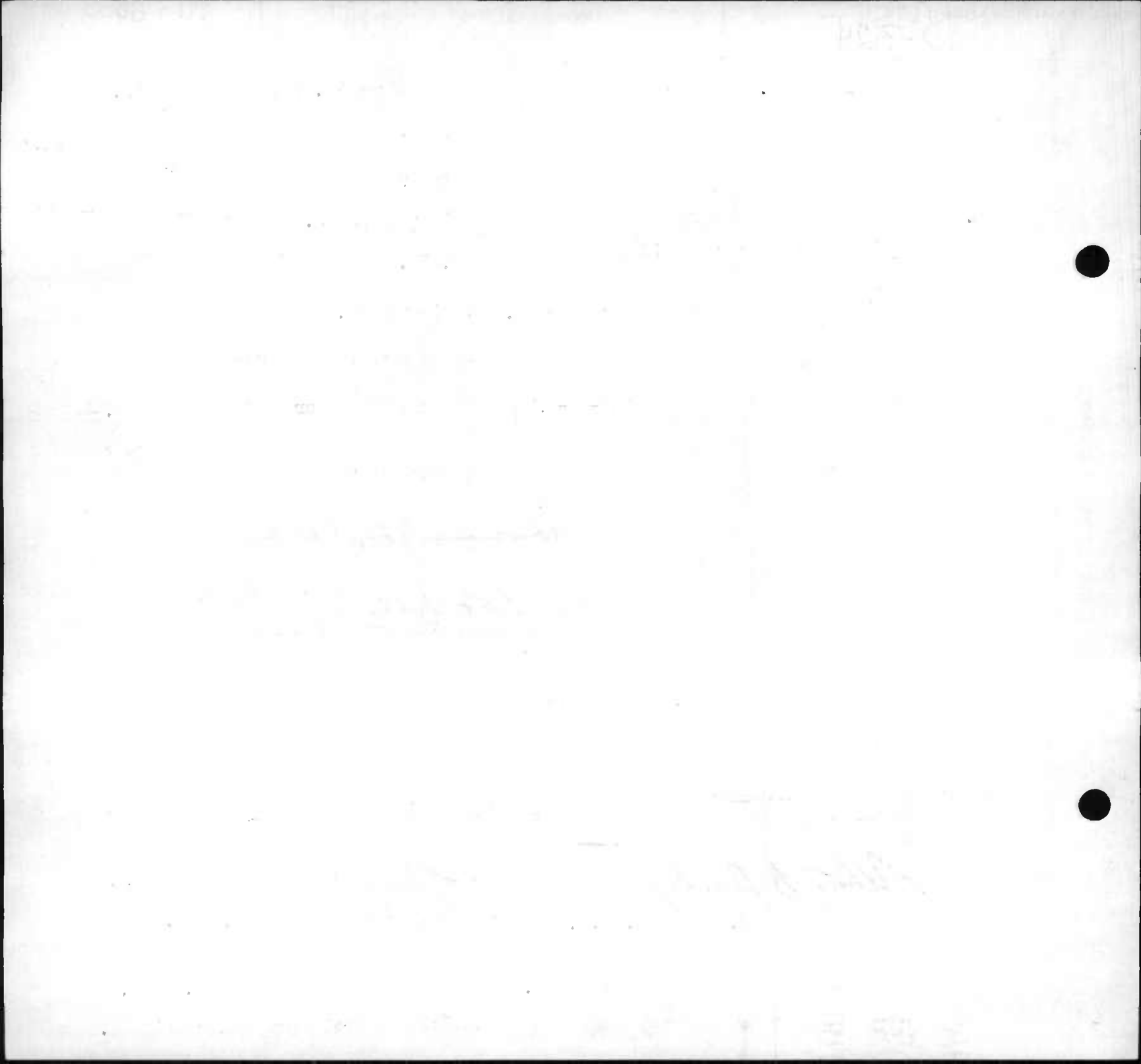
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6688</u>	
BIRTH NO. <u>W-620 70 6688</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>JESSIE MAE WARSAW</u>			2. DATE AND HOUR OF DEATH <u>6/30/70 10:50</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>MONTEBELLO STATE Hospital.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>603</u>		
5. SEX <u>F</u> 6. RACE <u>B.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>June 16, 1935</u> 9. AGE (In years last birthday) <u>35 years</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Henry Warsaw</u>			14. MOTHER'S MAIDEN NAME <u>Ollie Stevens</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Ollie Stevens</u>			ADDRESS <u>Same</u>		
18. <u>70211</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic adenocarcinoma 3 months</u> <u>no left arm -</u> (B) <u>Carcinoma of the lung.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/29/70</u> 19 <u>70</u> to <u>6/30</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D. DEGREE				23B. DATE SIGNED <u>6/30/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>JORGE G. FUXA</u>				23D. ADDRESS <u>2201 ARCONNE DR. BALT. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-3-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Smt Calvary Cmt.</u>	
24D. LOCATION (City, town, or county) <u>14 Cal County Md</u>		24E. (State) <u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>E.O. Wilson</u>	
				ADDRESS <u>1001 Brantley Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6689	
D-324 70 6689		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELLWOOD A. DITSCHLER		2. DATE AND HOUR OF DEATH June 26, 70. 12.35 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2642		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in Pines Bel aire		E. STREET AND NUMBER 4352 Sheldon Ave.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 30, 1905 65	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Continental Can Co.		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Adam Ditschler		14. MOTHER'S MAIDEN NAME Mary Vogelshang	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-03-3757		17. INFORMANT Marlene Ditschler 4352 Sheldon Ave. 21206	
18. 76214-096X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinomatous (B) Adenocarcinoma of Lung (bilateral) (C) Late Latent Syphilis Extensive Radiotherapy Old Myocardial Infarction Anemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 3 mos. ?		19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this doctor) attended the deceased from 6/24/1970 to 6/26/1970 and that (I) (we) last saw the deceased alive on 6/24/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 6/26/70	
23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY, M.D.		23D. ADDRESS 4900 Belair Road Balto., Md. 21206			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
24D. LOCATION (City, town, or county) (State) Parkville Balto. MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd.		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
70 6690 CERTIFICATE OF DEATH					Registered No. 70 6690				
BIRTH NO. H-250					M.E. CASE NO.				
1. NAME OF DECEASED (Type or Print) JULIA D HOGAN					2. DATE AND HOUR OF DEATH 6-29-70 5:45 P.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL					A. STATE MARYLAND B. COUNTY Baltimore				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
D. STREET ADDRESS (If rural, give location) 8103 Rider Ave 21204					E. DATE OF BIRTH 8/15/89				
					F. AGE (In years last birthday) XXX80				
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 8/15/89		9. AGE (In years last birthday) XXX80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) XXXXXXXXXXXX Ireland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Dowling					14. MOTHER'S MAIDEN NAME Bridget Ryan				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Anna Chambers-8103 Rider Avenue 21204		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction					CAUSE OF DEATH				
					INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					19A. DATE OF OPERATION				
					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 6-25 19 70 to 6-29 19 70 , that (I) (we) last saw the deceased alive on 6-29 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Gregorio Garfoni					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 6-29-70	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-2-1970		24C. NAME OF CEMETERY or CREMATORY Baltimore National			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR ADDRESS Armocost Funeral Chapel-4600 Liberty Hts				

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6691</u>	
F-635 BIRTH NO. <u>70 6691</u> 1. NAME OF DECEASED (Type or Print) <u>LOUIS FREEDMAN</u>		2. DATE AND HOUR OF DEATH <u>7-1-70 3:15 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>603</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>38 N. Patterson Park Ave</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/16/1906</u>	9. AGE (In years last birthday) <u>64</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rum</u>	
13. FATHER'S NAME <u>Solomon</u>			14. MOTHER'S MAIDEN NAME <u>Sally</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-32-6074</u>		17. INFORMANT <u>Mrs Esther Freedman</u>	
18. <u>2307 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Thrombosis</u> (B) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>diabetic mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>NO</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indify medical examiner <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that this (this hospital) attended the deceased from <u>6/24</u> 19 <u>70</u> to <u>7/1</u> 19 <u>70</u> that we (we) last saw the deceased alive on <u>7/1</u> 19 <u>70</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) not view the body after death.					
23A. SIGNATURE <u>Barredo, M.D.</u>				23B. DATE SIGNED <u>7/1/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>BARREDO, M.D.</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/2/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Covina</u>	
24D. LOCATION (City, town, or county) <u>Balto</u>		24E. LOCATION (State) <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 2 1970</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sylvan Lewis & Son</u>		25D. ADDRESS <u>9610 Reisterstown Rd</u>	

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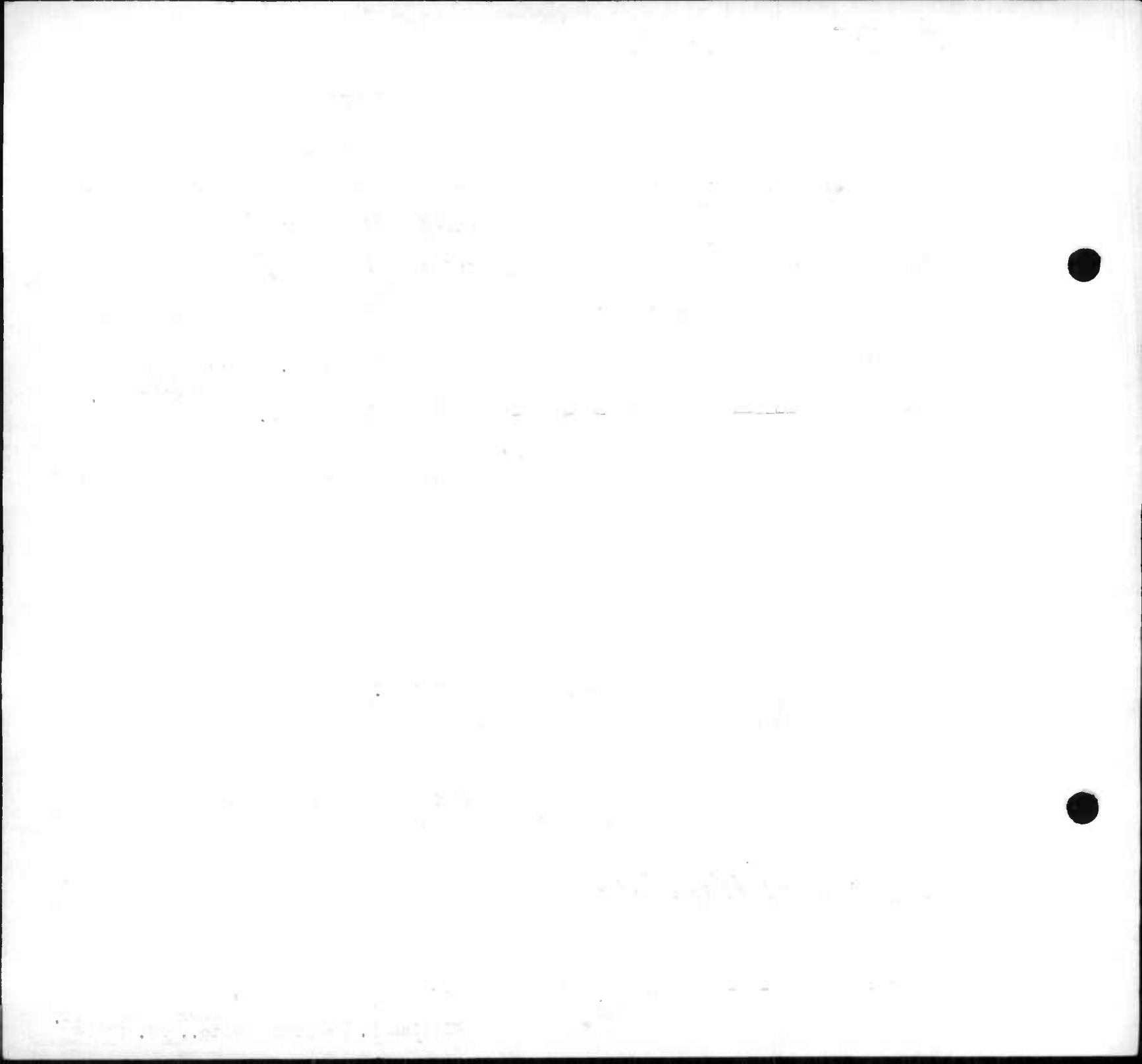
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FUNERAL DIRECTOR: IMPORTANT

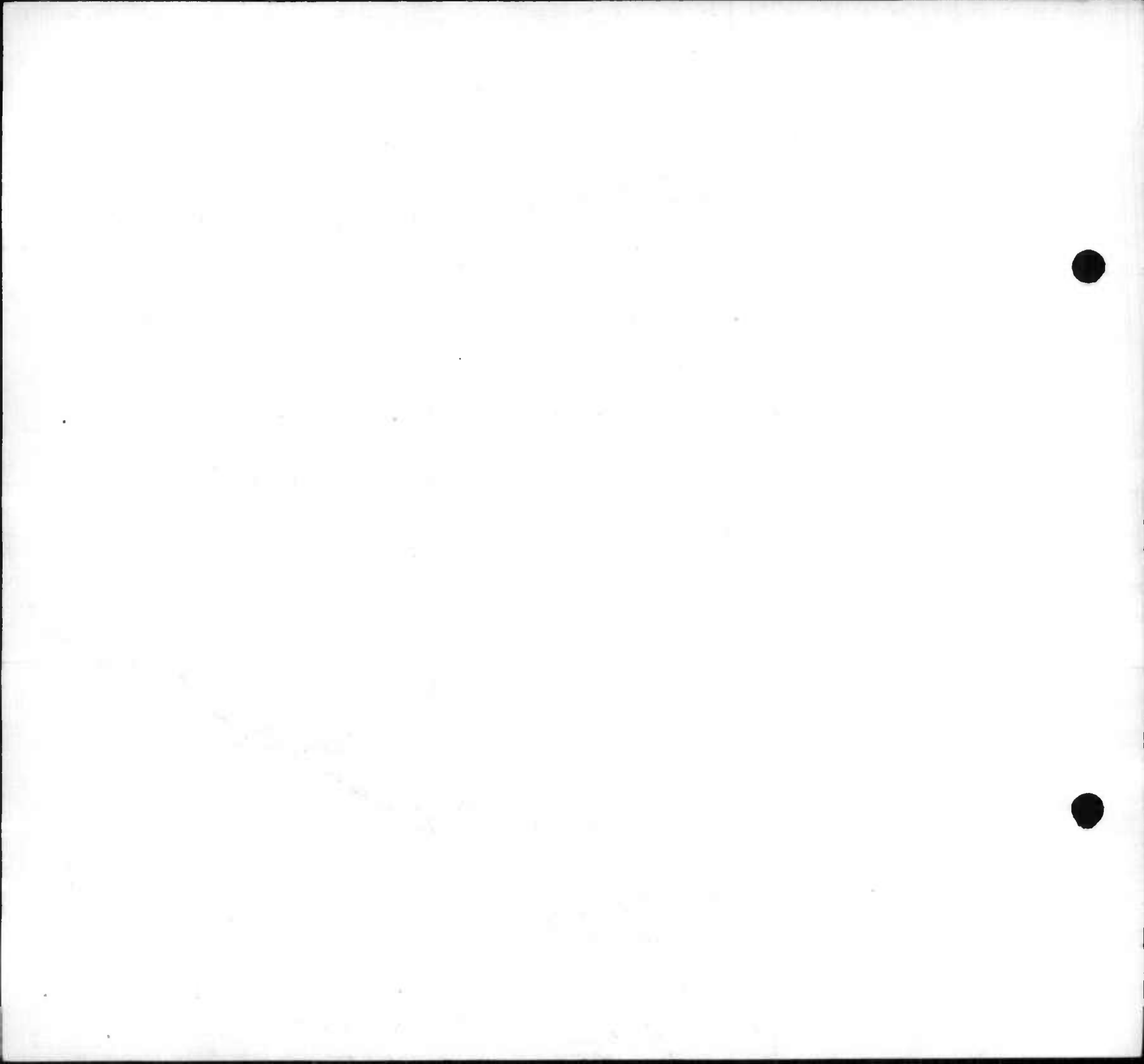
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
H-635 70 6692				70 6692		70 6692	
1. NAME OF DECEASED (Type or Print) LEO V. HARDING				2. DATE AND HOUR OF DEATH 1970-6-25-70 10 45P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY OF MD. HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY BALTI C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1618 NATORA RD			
5. SEX M	6. RACE CA W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-16-05		9. AGE (in years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY Weaving Mill		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harding				14. MOTHER'S MAIDEN NAME Mary E. Redman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-03-4083-A		17. INFORMANT CHAIR ADDRESS 1618 Natora Rd. 04		18. Barbara R. Kaiser	
18. 191X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH BRAIN TUMOR - (A) IMMEDIATE CAUSE ASTROCYTOMA GRADEY DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mo -	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 6-18-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-18-70 to 6-25-70 and that (I) (we) last saw the deceased alive on 6-25-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Daniel H. White				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6-25-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-29-70		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR William E. Johnson		ADDRESS 8521 Loch Raven Blvd. Balto., Md. 21204	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

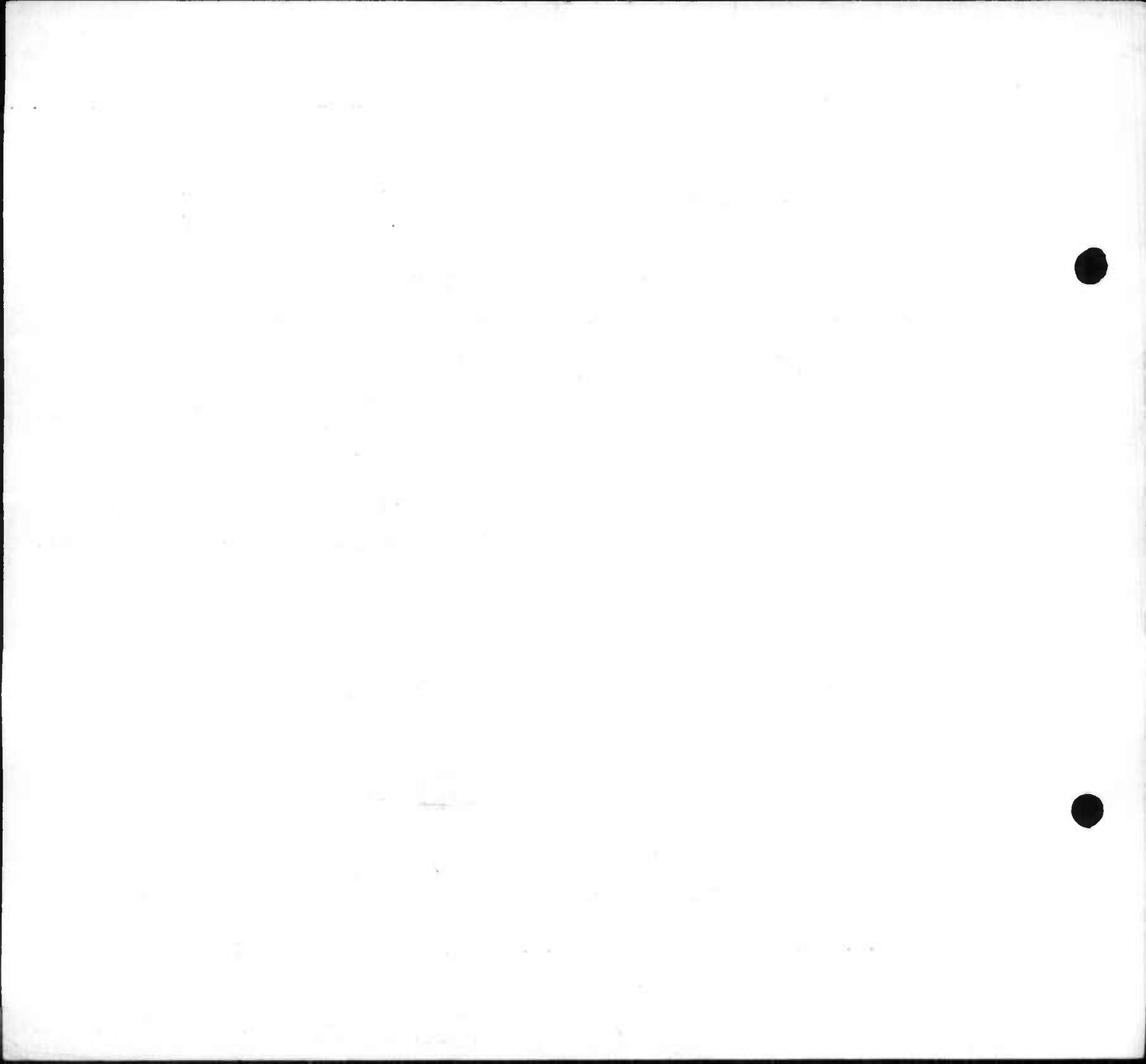
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6693	
H-520 70 6693				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		HENNICK WILLIAM PHILLIPS			
2. DATE AND HOUR OF DEATH		July 1, 1970 7 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		A. STATE MARYLAND		B. COUNTY 1307	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3740 ROLAND AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-97	9. AGE (In years last birthday) 72	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army Corps of Eng.		10B. KIND OF BUSINESS OR INDUSTRY Military		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME LOUIS HENNICK		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 214-38-8707		17. INFORMANT Louis G. Hennick - 308 Osborne Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE SUBARACNOID HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF: (B) ARTERIAL HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: (C)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from JULY 1 1970 to JULY 1 1970 that (I) (we) last saw the deceased alive on JULY 1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Miguel Karacuschansky M.D.		23B. DATE SIGNED July 1st, 1970		23C. PHYSICIAN'S NAME (Type) Miguel Karacuschansky M.D.	
23D. ADDRESS Union Memorial Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/70		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
24D. LOCATION (City, town, or county) Baltimore,		24E. ADDRESS M.D.			
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Ann Donovan - 3818 Roland Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 6694		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6694	
1. NAME OF DECEASED (Type or Print) MARY HATCHER			2. DATE AND HOUR OF DEATH 07-04-70 11:25 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 806		
5. SEX FEMALE			6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 07-12-98			9. AGE (In years last birthday) 71		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home		
11. BIRTHPLACE (State or foreign country) Parratan Va.			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME PETER CARTER			14. MOTHER'S MAIDEN NAME MARTHA ROBINSON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 219-56-4681		17. INFORMANT Mrs. Kezia S. Smith
18. CAUSE OF DEATH 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST MYOCARDIAL INFARCTION 8 DAYS ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SMALL BOWEL INFARCTION 2 DAYS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 7-2-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SMALL BOWEL INFARCTION		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? JUNE	
22. I certify that (X) (this hospital) attended the deceased from JULY 25 1970 to JULY 4 1970 that (X) (we) last saw the deceased alive on JULY 4 1970 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. E. Eckhauser MD			23B. DATE SIGNED 7-5/70		23C. PHYSICIAN'S NAME (Type) F. E. ECKHAUSER
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7-6-70		24C. NAME OF CEMETERY OR CREMATORY St. Paul's Church Cemetery	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD		24E. FUNERAL DIRECTOR Robert E. Taylor, M.D.			
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Robert E. Taylor, M.D.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JAMES GROSS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 5 1970 Hour 4:20 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 246 N. Fulton Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 5 1970 4:20 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2001	
9. DATE OF BIRTH 7-17-1929		10. AGE (In years last birthday) 41	
11. BIRTHPLACE (State or foreign country) BALTO. Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM GROSS		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR	
15. MOTHER'S MAIDEN NAME ELIZABETH HENSON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 8-5-44 TO 10-2-47	
17. SOCIAL SECURITY NO. 217-20-445		18. INFORMANT MYRTLE WARRINGTON	
19. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Isidore Mihalakis</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7-5-70 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-9-1970	
24C. NAME OF CEMETERY or CREMATORY MC CALVARY CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO. Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 2 1970		25B. NAME OF REGISTRAR Robert E. Barber, M.D.	
25C. FUNERAL DIRECTOR Dedrick W. Hayes		ADDRESS 3112 Penterstown Rd	

ACADEMY BONDS

W-420

1

70

6696

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70

6696

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ISIAH WILLIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD HOSPITAL ADDRESS OR LOCATION 1809 Brunt Street 7-23-70		3. DATE PRONOUNCED DEAD Month Day Year Hour July 2, 1970 10:05 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 1/7/39		10. AGE (In years last birthday) 31	
11. BIRTHPLACE (State or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		14B. KIND OF BUSINESS OR INDUSTRY Private Family	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-34-0313	
15. MOTHER'S MAIDEN NAME Marie Branton		18. INFORMANT ADDRESS Marie Branton - 1809 Brunt St	
19. 304.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Patty Metamorphosis of Liver (A) IMMEDIATE CAUSE Intravenous Narcotism DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7/7/70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/3/70	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/7/70	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. P.R.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. 10/10/70		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	

S-336 70 6697

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6697

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Harry Stauter

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 City Hospitals

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

BALTIMORE

C. CITY OR TOWN

DUNDALK
Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☒

6. SEX

male

7. RACE

white

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

JUNE 12, 1907

10. AGE (in years
last birthday)

63

Under 1 Yr. # Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1907 Queensway

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

UNK.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CARPENTER

14B. KIND OF BUSINESS OR INDUSTRY

CONSTR.

15. MOTHER'S MAIDEN NAME

UNK.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

170-12-4500

18. INFORMANT

ADDRESS

AS

MARY JANE STAUTER - WIFE - ABOVE

19.

412.4 I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

NO

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

6/30/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7-3-1970

24C. NAME OF CEMETERY or CREMATORY

ALTO REST

24D. LOCATION (City, town, or county) (State)

ALTONA, PENNA.

25A. DATE REC'D BY HEALTH DEPT.

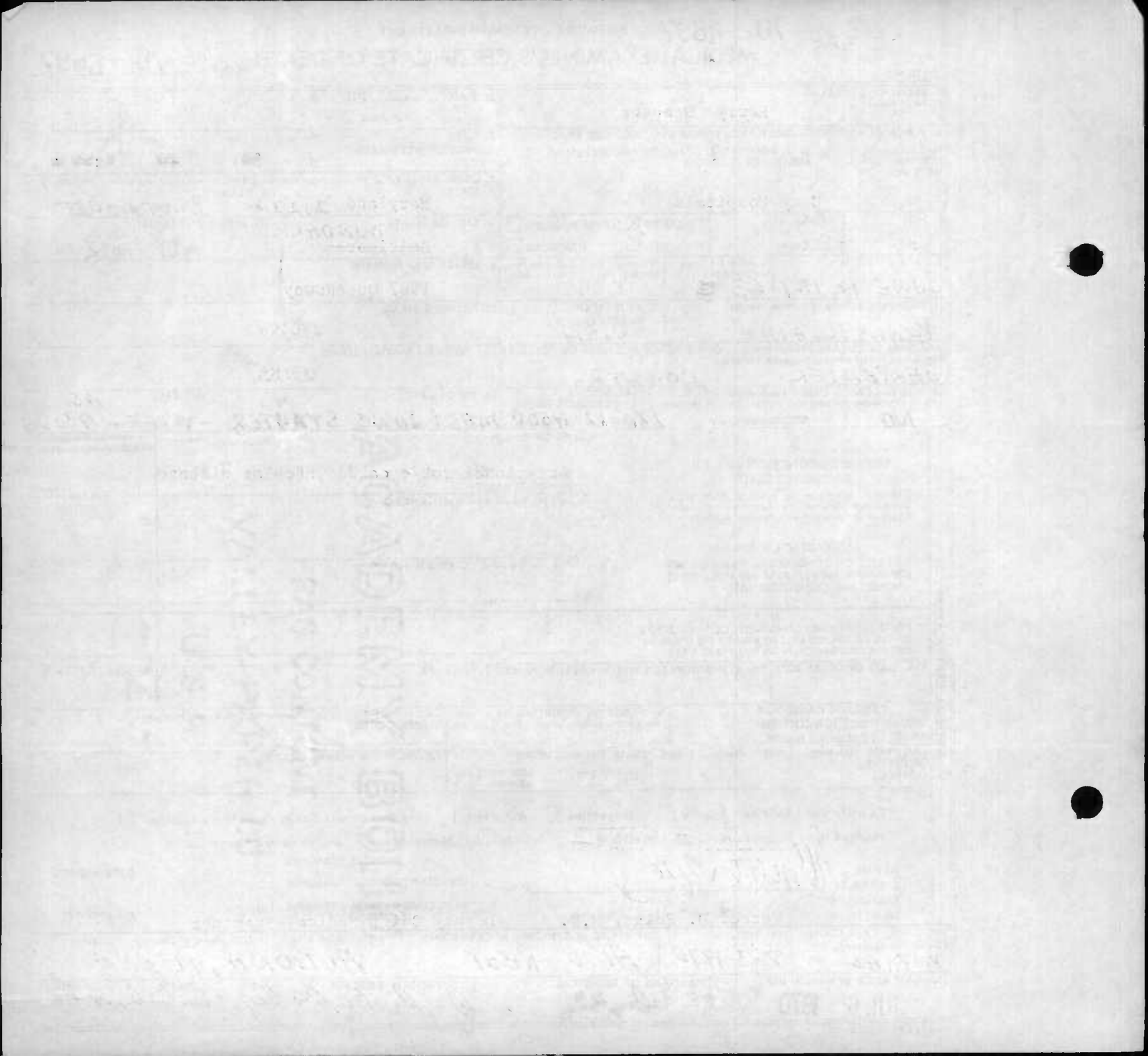
JUL 6 1970

25B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

25C. FUNERAL DIRECTOR

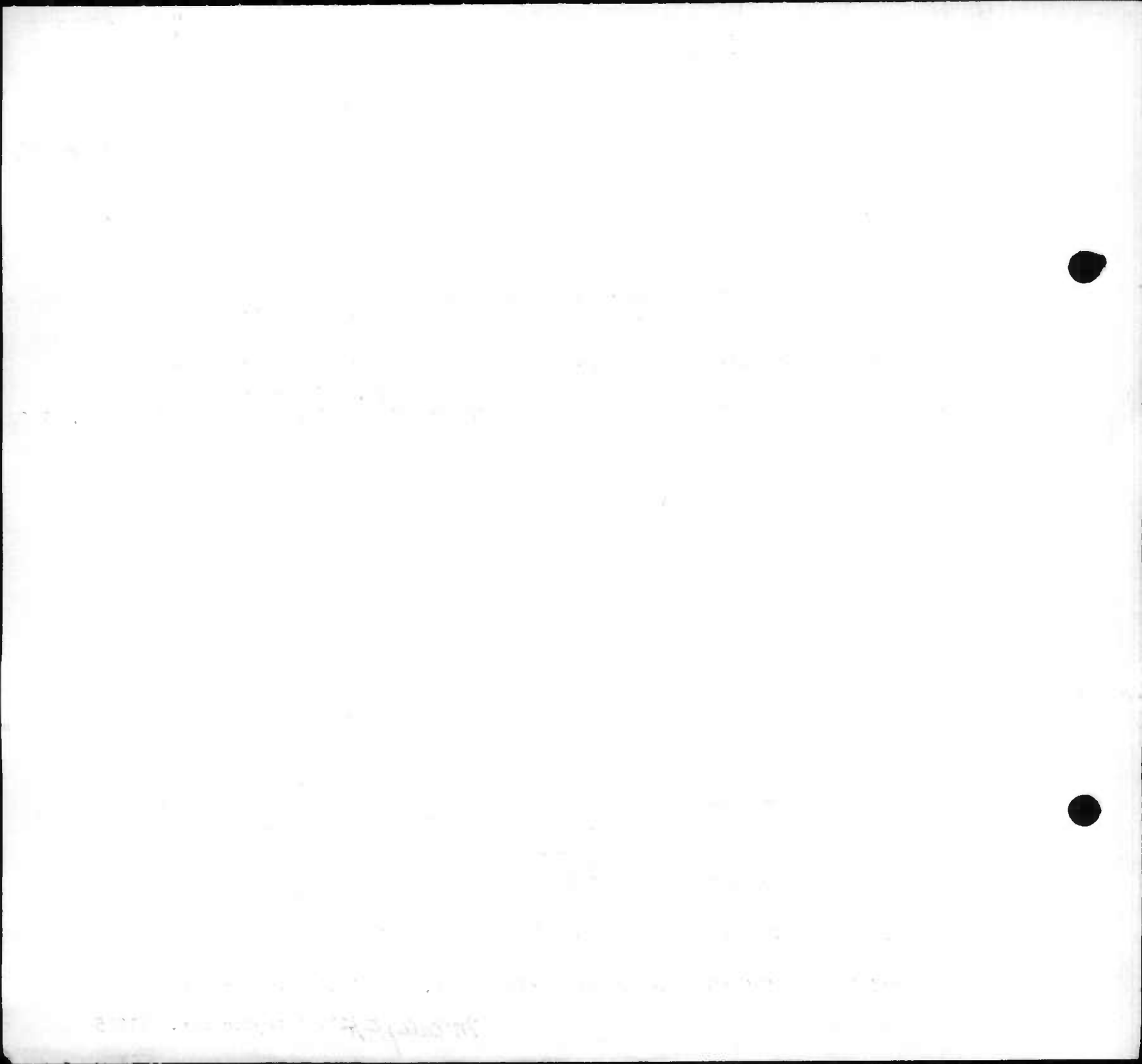
W. Broder Bradley, Dundalk, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6698	
G-163 70 6698		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) GEBHARDT, BLAIR Charles		2. DATE AND HOUR OF DEATH 7/3/70 5 25 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ANN ARUNDEL	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND 38		C. CITY OR TOWN PASADENA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 114 MONTROSE RD. 21122			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/7/11
		9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10B. KIND OF BUSINESS OR INDUSTRY Associated PRINTING Co.	
11. BIRTHPLACE (State or foreign country) MARYLAND (Balto)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Gebhardt		14. MOTHER'S MAIDEN NAME Blondell Hurdell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1942-1946 WW2		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Mrs. Alice Gebhardt		ADDRESS 114 Montrose Rd. 21122	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIORESPIRATORY ARREST (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY ARTERY DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) NONE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 MIN. 8 YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). NONE			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE		21D. TIME OF INJURY (Approx.) NONE	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> NONE		21F. HOW DID INJURY OCCUR? NONE	
22. I certify that (I) (this hospital) attended the deceased from 7/1/70 19 70 to 7/3 19 70 that (I) (we) lost saw the deceased alive on 7/3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE James Allan MD		23B. DATE SIGNED 7/3/70	
23C. PHYSICIAN'S NAME (Type) JAMES ALLAN		23D. ADDRESS MD 110 W 39th ST	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/7/70	24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR McCully F.R.		ADDRESS 237 Patapsco Ave. 21225	



C-200

70

6699

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70

6699

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

EDWARD COOK

2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1209 W. Lombard St.

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

M.

7

1

1970

12:35A

5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)

A. STATE

Md.

B. COUNTY

302

6. SEX

Male

7. RACE

White

8. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2/17/1904

10. AGE (in years last birthday)

66

11. Under 1 Yr. 12 Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1209 W. Lombard St.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Lorenz How Cook

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Bookkeeper

14B. KIND OF BUSINESS OR INDUSTRY

Bookkeeper

15. MOTHER'S MAIDEN NAME

Ellie Melyard

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

18. INFORMANT

Mrs. Margorie Cook - 1209 W. Lombard St.

ADDRESS

19.

412.4

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

0

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/3/70

24C. NAME OF CEMETERY OR CREMATORY

Parsons Cemetery

24D. LOCATION

(City, town, or county)

(State)

Parsons W. Virginia

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

John J. Grogan & Son Inc.

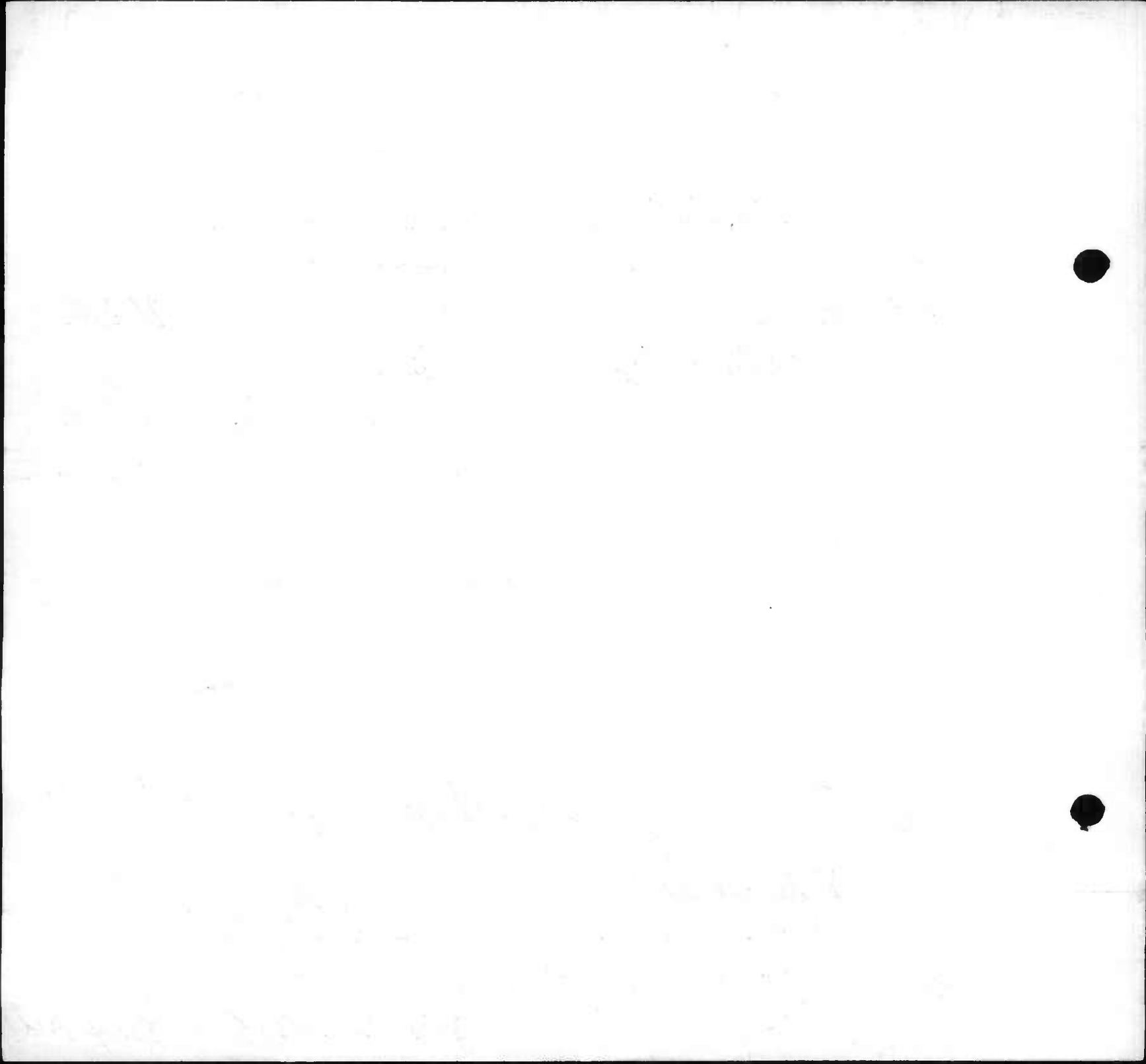
ADDRESS

Hollins

Balto. 23, Md.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
B-616 70 6700				70 6700	
1. NAME OF DECEASED (Type or Print) Sophia Barber			2. DATE AND HOUR OF DEATH 6-30-70 3:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland, Baltimore C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 801 Silver Avenue 21219 005		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-96	9. AGE (in years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Petrovitz		14. MOTHER'S MAIDEN NAME York	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 4940 Eastern Avenue BCH-Records Baltimore, Maryland 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF: CHF (B) DUE TO, OR AS A CONSEQUENCE OF: Mitral Stenosis, Mitral Insuff APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 yrs					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Inotify medical examiner <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/22 19 70 to 6/30 19 70 that (I) (we) last saw the deceased alive on 6/30 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward J. Lee MD		23B. DATE SIGNED 6/30/70		23C. PHYSICIAN'S NAME (Type) Edward J. Lee MD	
23D. ADDRESS 4940 Eastern Avenue BCH- Baltimore, Maryland 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/3/70		24C. NAME OF CEMETERY OR CREMATORY Oak-Lawn Cem.		24D. LOCATION (City, town, or county) (State) Balto Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR J. G. Connelly Sons	
				ADDRESS Essex Md.	

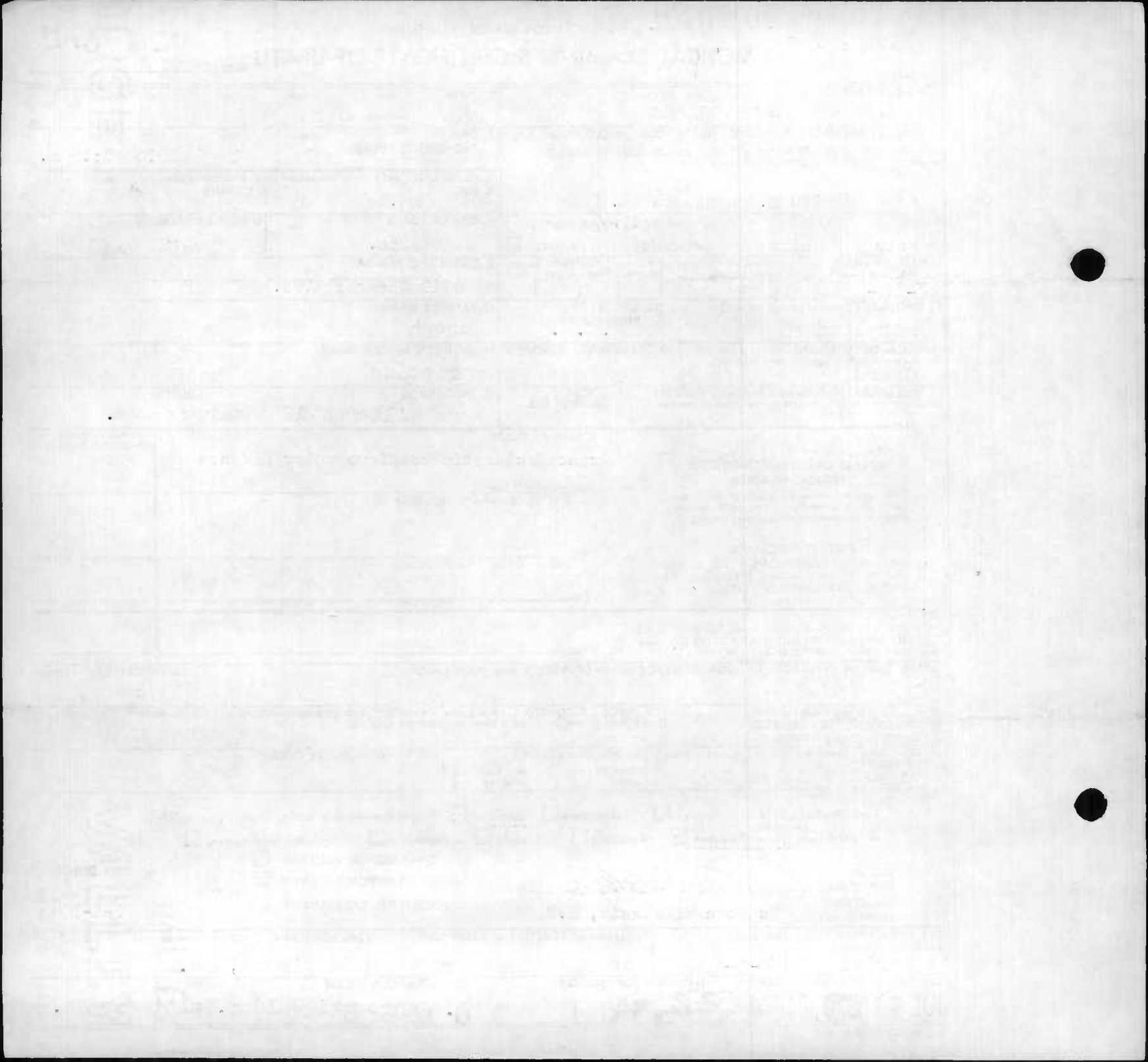


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

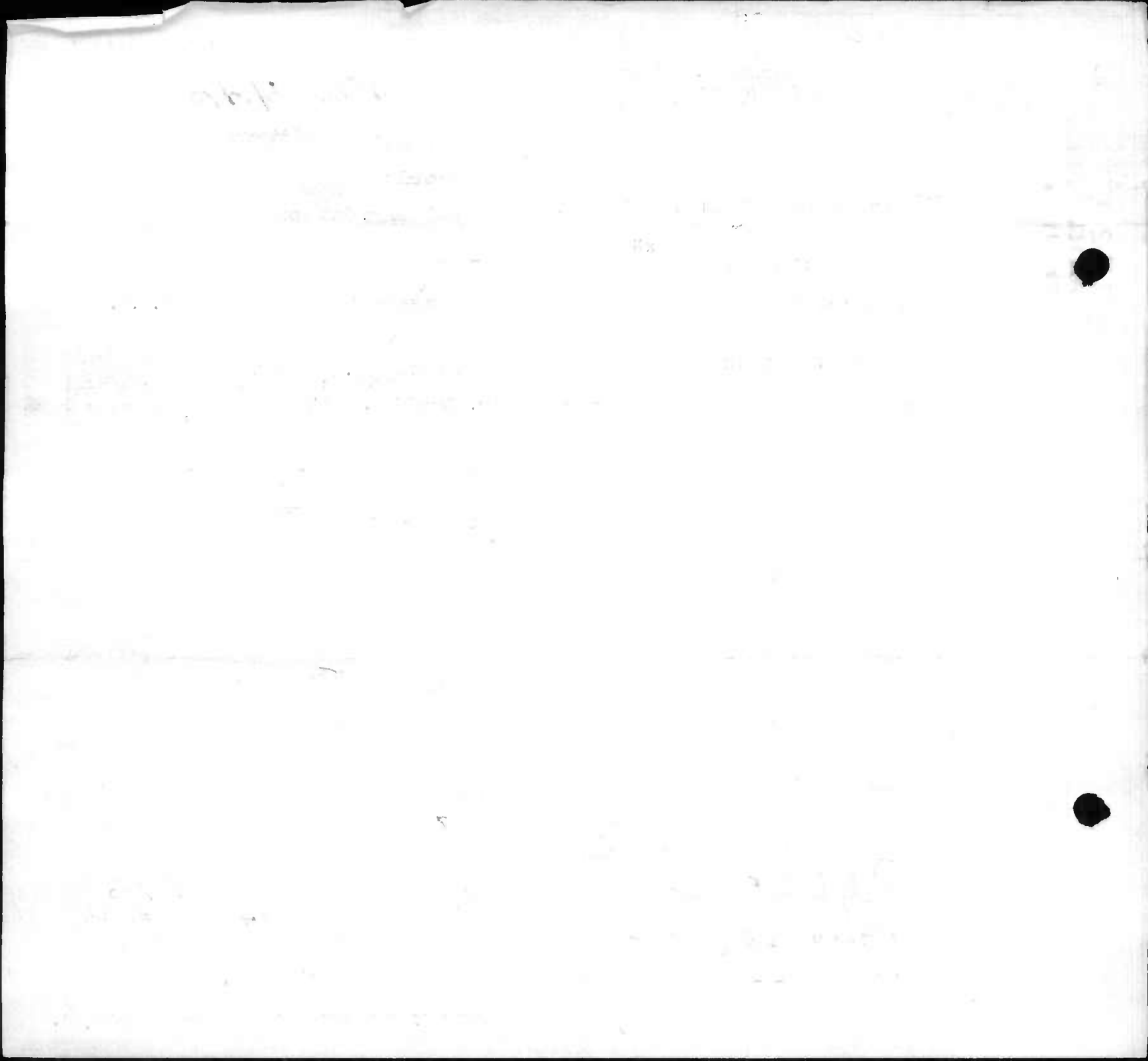
1. NAME OF DECEASED (Type or Print) ELMER MILLER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 100 E. Baltimore St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 1 1970 7:15 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2642	
9. DATE OF BIRTH 2-12-1906		10. AGE (in years last birthday) 64	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gaurd		15. MOTHER'S MAIDEN NAME Christine	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Rose Miller		ADDRESS 4712 Shamrock Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> 7-1-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-70	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR B. Dabrowski		ADDRESS 2818 E. Baltimore St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6702		X		REG. NO. 70 6702	
BIRTH NO. 70 6702									
1. NAME OF DECEASED (Type or Print) Sharon N. Rytter SHARON RYTTER					2. DATE AND HOUR OF DEATH 4:10 pm 6/30/70				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN B. Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8240 Longpoint Road				
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-11-45		9. AGE (In years last birthday) 24	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT OATMAN					14. MOTHER'S MAIDEN NAME MARTHA L. NELSON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-42-8976		17. INFORMANT Husband: Mr. Gerald J. Rytter Address 8240 Longpoint Road Dundalk, Maryland 21222			
18. 426 X I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE CARDIO respiratory arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Anorexia, cor pulmonale DUE TO, OR AS A CONSEQUENCE OF: (C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 6/19			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/19 19 70 to 6/30 19 70 that (I) (we) last saw the deceased alive on 6/30 19 70 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ralph DeFrongo					23B. DATE SIGNED 6/30/70			23C. PHYSICIAN'S NAME (Type) RALPH DEFONGO	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 7-3-70		24C. NAME OF CEMETERY or CREMATORY Oak Lawn		
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970				
25B. NAME OF REGISTRAR John J. Duda					25C. FUNERAL DIRECTOR John J. Duda				
25D. ADDRESS 7922 Wise Avenue Dundalk, Md.									



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6703

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ARTHUR S. WESSEL

2. DATE OF DEATH
Known ☐ Month Day Year Hour
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour
6 30 1970 4:15 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Md. B. COUNTY BALTO. 5300

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

JAN 30, 1916

10. AGE (In years lost birthday)

54

11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

110 Maple Ave.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ARTHUR William Wessel

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Gas + Electric

15. MOTHER'S MAIDEN NAME

MARY E. Bassler

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

Emily R. Wessel 110 Maple Ave 21228

ADDRESS

19.

412.4 I

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Nature causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-1-70

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

July 3 1970

24C. NAME of CEMETERY or CREMATORY

ST. Paul

24D. LOCATION (City, town, or county) (State)

FULTON

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 6 1970

25B. NAME OF REGISTRAR

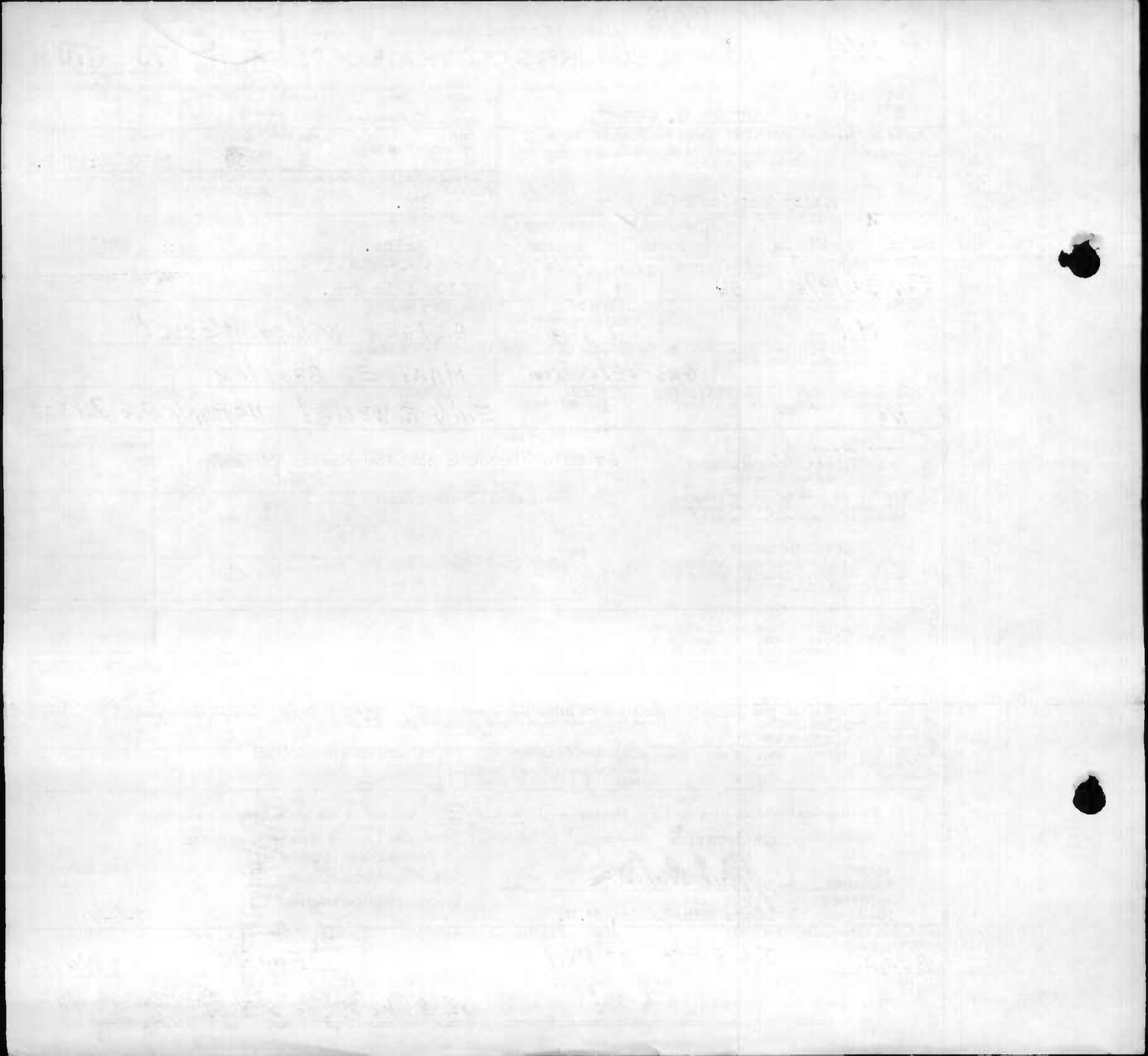
Isidore Mihalakis, M.D.

25C. FUNERAL DIRECTOR

G. E. MacMillan

ADDRESS

301 Frederick Rd
Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6704	
<div style="display: flex; justify-content: space-between;"> K-610 70 6704 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		ROBERT TILDEN KIRBY		2. DATE AND HOUR OF DEATH July 1, 1970 6²⁰ A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Caton & Wilkens Avenues			C. CITY OR TOWN Halethorpe D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 4420 Ridge Avenue					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1915	9. AGE (In years last birthday) 55	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George R. Kirby			14. MOTHER'S MAIDEN NAME Martha Allen Coleman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-03-8233	17. INFORMANT ADDRESS Mrs. Ella Mae Kirby, 4420 Ridge Ave. 21227		
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p style="font-size: 1.2em;">410.9 + 1250.9</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: coronary thrombosis sudden</p> <p>(B) arteriosclerotic cardiovascular disease</p> <p>(C) _____</p> </div> <div style="flex: 1;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/1 19 69 to 7/1 19 70 , that (1) (we) lost saw the deceased alive on 7/22 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Herbert J. Levickas M.D.				23B. DATE SIGNED 7/2/70	
23C. PHYSICIAN'S NAME (Type) Herbert J. Levickas				23D. ADDRESS 5404 East Drive, Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-1970		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
24D. LOCATION Washington Blvd. Howard Co., Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Kirby		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

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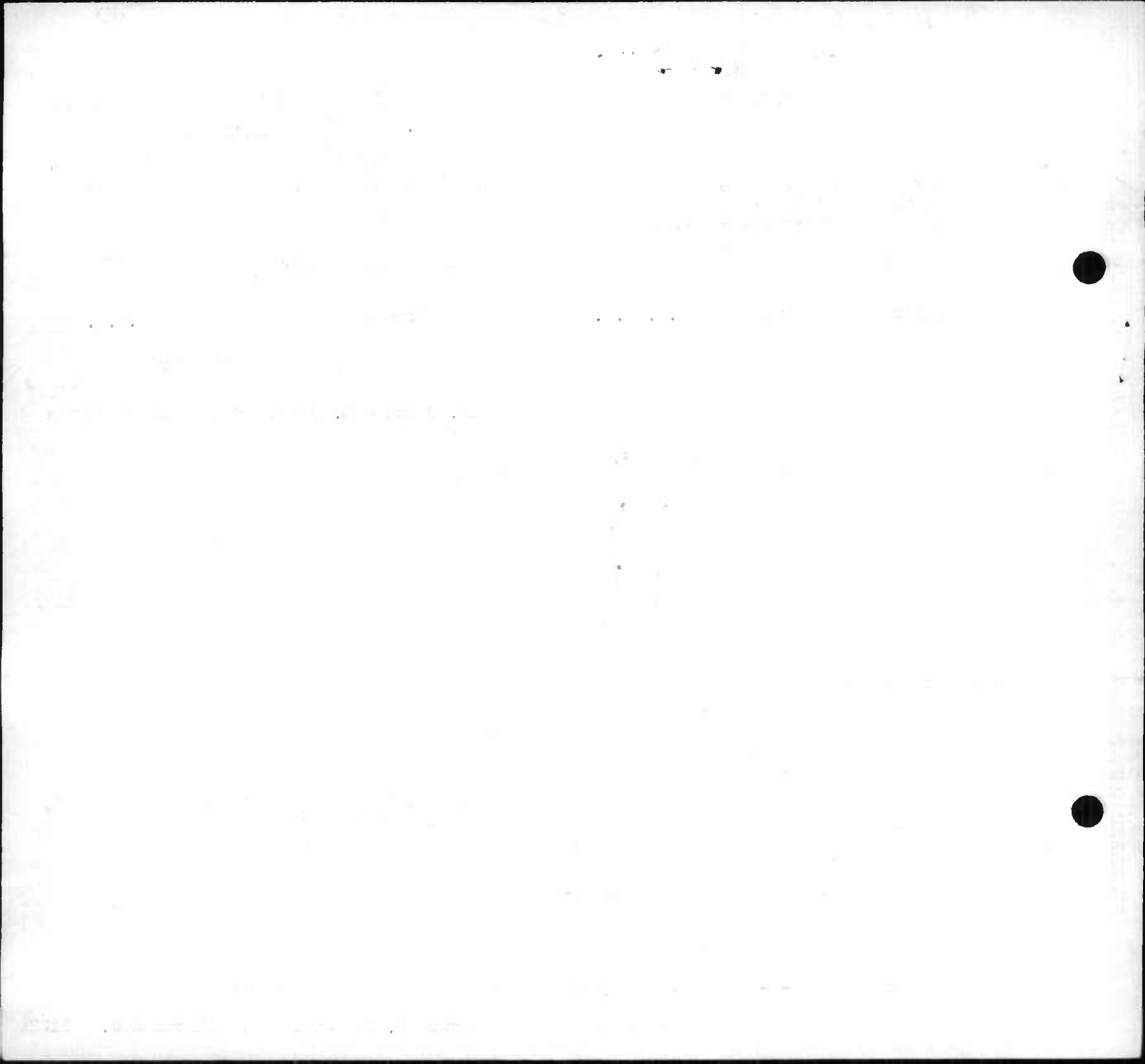
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

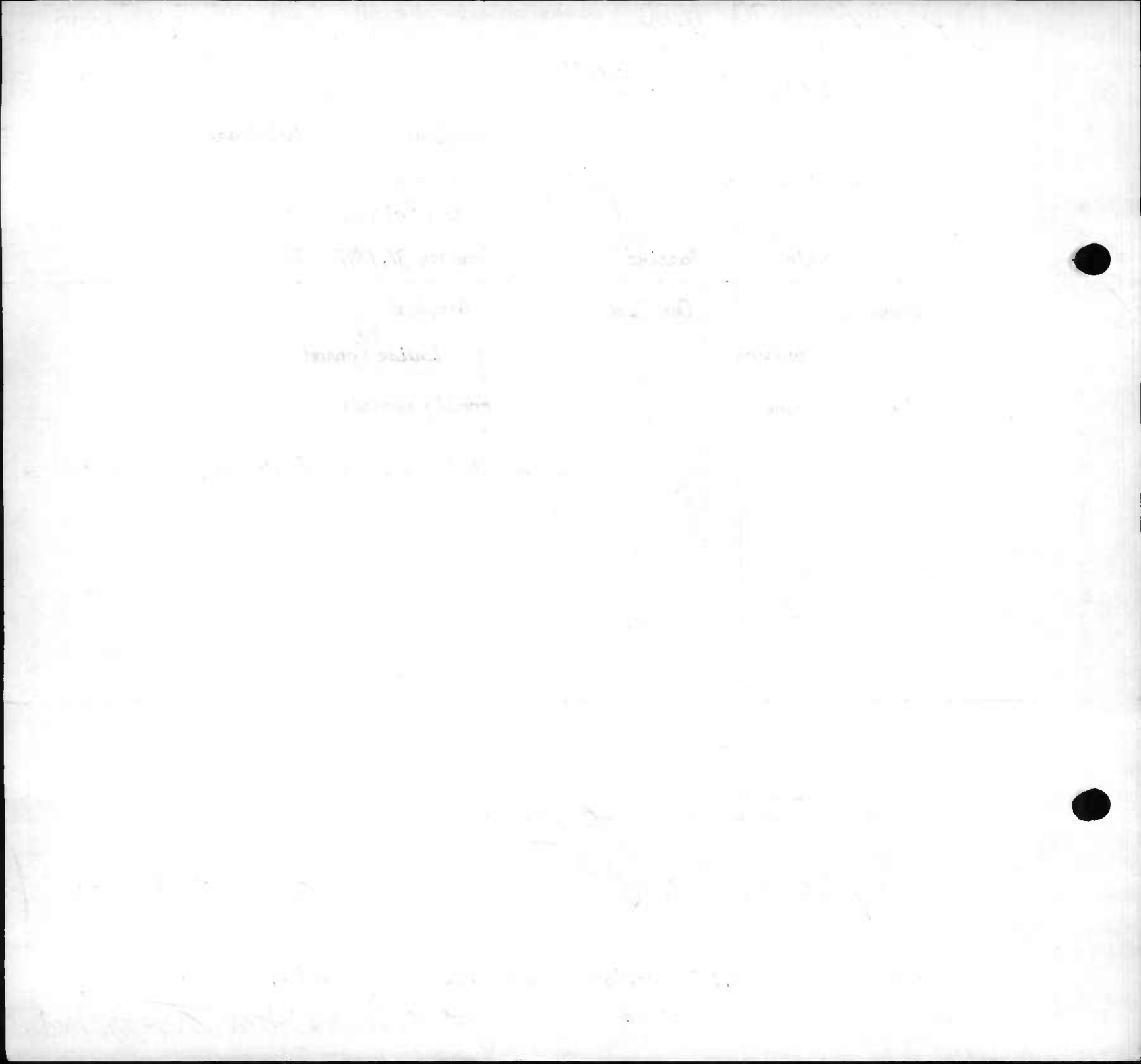
B-620 70 6705		BALTIMORE CITY HEALTH DEPARTMENT		70 6705	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Louis Beares</u>		2. DATE AND HOUR OF DEATH <u>July 1, 1970 12:00 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> <u>3601 N. Broadway</u> <u>Baltimore, Maryland</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>LANSDOWNE</u> D. INSIDE CITY LIMITS? <u>XXXXXXXX</u> MD. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3275 Ryerson Circle</u> <u>21227</u>			
5. SEX <u>MALE</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-11</u>	9. AGE (in years last birthday) <u>58</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B.O. R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Harry Beares</u>			
14. MOTHER'S MAIDEN NAME <u>Margaret Vineyard</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Theresa L. Flair, 3275 Ryerson Circle</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Subpyrene abscess</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of the Colon</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>16/30/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Subpyrene Abscess</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12:01 AM 7/1/70</u> to <u>2 AM 7/1/70</u> that (II) (we) last saw the deceased alive on <u>12 AM 7/1/70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gregory B. Bulkley, MD</u>		23B. DATE SIGNED <u>7/1/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Gregory B. Bulkley, MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-4-1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

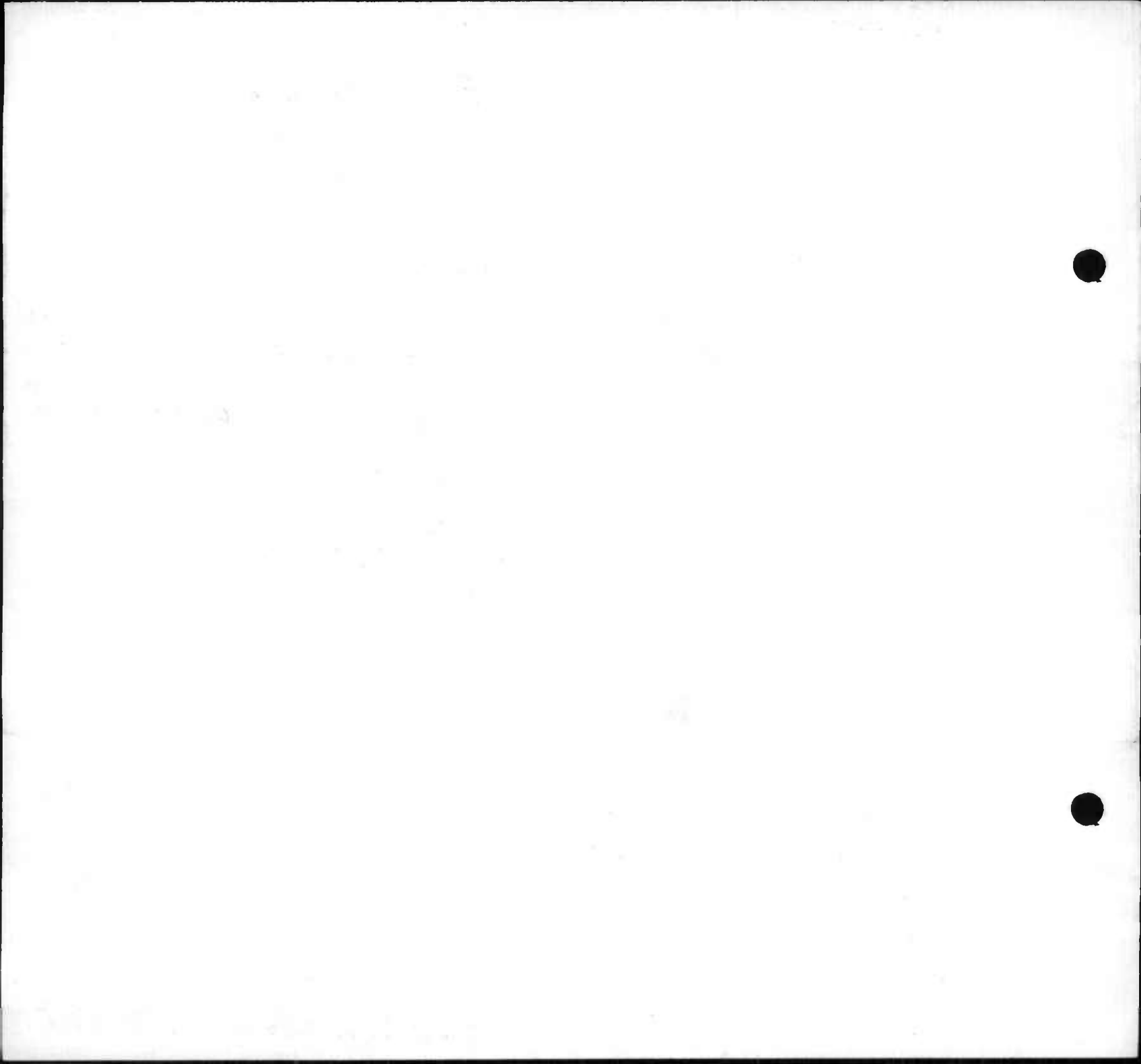
<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH Registered No. 70 6706</p>			
<p>1. NAME OF DECEASED (Type or Print) ELsie C. Purcell</p>		<p>2. DATE AND HOUR OF DEATH 30 Jun 70 7:00 AM</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland B. COUNTY Baltimore</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson</p> <p>D. STREET ADDRESS (If rural, give location) 605 Fairway Drive</p>	
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married</p>	<p>8. DATE OF BIRTH January 31, 1897</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Own Home</p>	<p>9. AGE (In years last birthday) 73</p>
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Charles Krummeck</p>		<p>14. MOTHER'S MAIDEN NAME Louise Conrad</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>	<p>16. SOCIAL SECURITY NO. None</p>	<p>17. INFORMANT Family records</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 I</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH</p> <p>(A) MYOCARDIAL INFARCTION 12 hours</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 12 hours</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>19A. DATE OF OPERATION 10.9</p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No)</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 29 Jun 70 to 30 Jun 70 that (I) (we) last saw the deceased alive on 30 Jun 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE J. Burkhardt M.D.</p>		<p>23B. DATE SIGNED 30 Jun 70</p>	<p>23C. PHYSICIAN'S NAME (Type) John Burns, Son, Towson, Md.</p>
<p>23D. ADDRESS M.D.</p>		<p>24. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	
<p>24A. DATE July 2, 1970</p>	<p>24B. NAME OF CEMETERY or CREMATORY Moreland Memorial Park</p>	<p>24C. LOCATION (City, town, or county) Parkville, Maryland</p>	<p>24D. (State)</p>
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</p>	<p>25C. FUNERAL DIRECTOR John Burns, Son, Towson, Md.</p>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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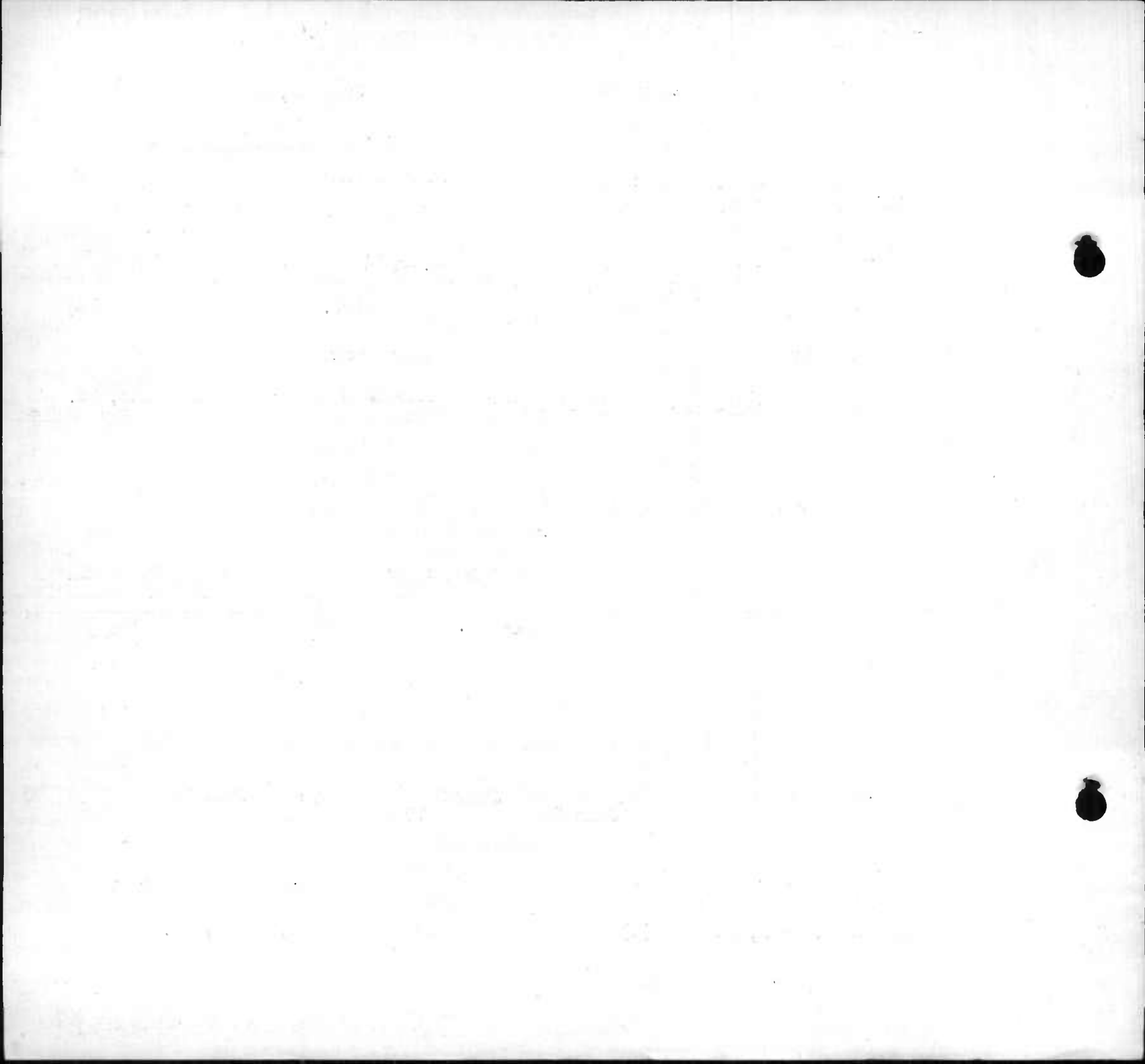
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6707</u>
P-655 <u>70 6707</u>				
BIRTH NO.				
1. NAME OF DECEASED (Type or Print) <u>MR PERRYMAN LYNWOOD R.</u>		2. DATE AND HOUR OF DEATH <u>4:30 AM Second of July 1970</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>The Union Memorial Hospital</u> <u>44 Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>M</u> 6. RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>05-05-02</u> 9. AGE (In years last birthday) <u>68</u> 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>ROBBER TIRE</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>				
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>223-24-7789</u>		17. INFORMANT <u>Manly Thompson 381 DOAK AVE MD</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>		
		(B) <u>lung's carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF:		
		(C) <u>Cirrhosis of liver</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from <u>6/12/70</u> 19 <u>70</u> to <u>7/2</u> 19 <u>70</u> that (I) <u>did</u> last/saw the deceased alive on <u>7/1</u> 19 <u>70</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>7/2/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Luis PINTADO MD.</u>		23D. ADDRESS <u>UNION MEMORIAL HOSP.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-6-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Woodlawn</u>
24D. LOCATION (City, town, or county) <u>Baltimore</u>		(State) <u>MD</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>		25B. NAME of REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>3615 Chestnut Ave.</u>



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										
H-200 70 6708					CERTIFICATE OF DEATH					
BIRTH NO.					REG. NO. 70 6708					
1. NAME OF DECEASED (Type or Print) Raymond Elmer Haag					2. DATE AND HOUR OF DEATH June 26, 1970 7 A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) US Public Health Service Hospital 3100 Wyman Parkway					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Prince Georges C. CITY OR TOWN Mitchellville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 12901 Woodmore Road					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/11/24	9. AGE (In years last birthday) 45		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10B. KIND OF BUSINESS OR INDUSTRY U. S. GOVERNMENT Fed. Aviation Adm.		11. BIRTHPLACE (State or foreign country) Mich.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Haag					14. MOTHER'S MAIDEN NAME Emma Kuehn					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USAF 1943-1945				16. SOCIAL SECURITY NO. 373-20-4434		17. INFORMANT DOROTHY G. HAAG ADDRESS Records - US PHS Hospital, Balto, Md. Same as #4 ABOVE				
18. 203 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gangrene of inferior surface of brain ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Gangrene of nose Multiple myeloma					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gangrene of inferior surface of brain (B) DUE TO, OR AS A CONSEQUENCE OF: Gangrene of nose (C) DUE TO, OR AS A CONSEQUENCE OF: Multiple myeloma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Days Months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hepatitis					Days					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from June 2 19 70 to June 26 19 70 , that (I) (we) last saw the deceased alive on June 26 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Samuel P. Ward, M.D. DEGREE							23B. DATE SIGNED 6/26/70			
23C. PHYSICIAN'S NAME (Type) SAMUEL P. WARD, Surgeon (R) DEGREE					23D. ADDRESS US PHS Hospital, Balto, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JUNE 29, 1970		24C. NAME OF CEMETERY OR CREMATORY TRINITY LUTHERAN CEMETERY BOWIE, MARYLAND		24D. LOCATION (City, town, or county) (State) BOWIE, COUNTY MARYLAND				
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970			25B. NAME OF REGISTRAR Robert E. Taylor, R.G.			25C. FUNERAL DIRECTOR BWCHAMBERS Co. RIVERDALE, Md.			ADDRESS	



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S. 432

1. NAME OF DECEASED (Type or Print) SCHILDWACHTER WILLIAM SVHILZWACHTER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> July 1, 1970 7:20 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1, 1970 7:20 P. M.	
6. SEX Male		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov 7-1892		10. AGE (In years last birthday) 77	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY SCHILDWACHTER		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -	
15. MOTHER'S MAIDEN NAME MARGARET		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI US NAVY	
17. SOCIAL SECURITY NO.		18. INFORMANT FAMILY	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		20. DATE OF OPERATION 0	
21. AUTOPSY? (Yes or No) No		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
25. TIME OF INJURY (APPROX.)		26. HOW DID INJURY OCCUR?	
27. DATE REC'D BY HEALTH DEPT. JUL 6 1970		28. NAME OF REGISTRAR Robert E. Taylor, M.D.	
29. FUNERAL DIRECTOR John H. HAHN, 4200 PENNINGTON AVE		30. ADDRESS	

19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		20. DATE OF OPERATION 0	
21. AUTOPSY? (Yes or No) No		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		24. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
25. TIME OF INJURY (APPROX.)		26. HOW DID INJURY OCCUR?	
27. DATE REC'D BY HEALTH DEPT. JUL 6 1970		28. NAME OF REGISTRAR Robert E. Taylor, M.D.	
29. FUNERAL DIRECTOR John H. HAHN, 4200 PENNINGTON AVE		30. ADDRESS	

ACADEMIC POND

THE JOURNAL

BY THE EDITOR

NO. 1

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THE JOURNAL OF THE ACADEMIC POND

1916

1917



1		70 6710		BALTIMORE CITY HEALTH DEPARTMENT		70 6710	
W-436		MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
BIRTH NO.		REG. NO.					
1. NAME OF DECEASED (Type or Print)		George P. Walter		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 29 70 5:15 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		St. Agnes Hospital		3. DATE PRONOUNCED DEAD		Month Day Year Hour 6 29 70 5:15 a.m.	
6. SEX male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Howard	
9. DATE OF BIRTH 6-30-1926		10. AGE (in years lost birthday) 43		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Boswell Walter		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preaching Agent		15. MOTHER'S MAIDEN NAME Ruth Knight		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 2	
17. SOCIAL SECURITY NO. 290-14-7851		18. INFORMANT Bessie Walter		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		20. DATE OF OPERATION 2	
21. ANATOMY? (Yes or No) yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		24. LOCATION (City, town, or county) (State) Ellicott City Md	
25. DATE REC'D BY HEALTH DEPT. JUL 6 1970		26. NAME OF REGISTRAR Robert E. Fisher		27. FUNERAL DIRECTOR Higginbottom-Slack		28. ADDRESS Ellicott City Md	
29. DATE OF BIRTH 6-30-1926		30. AGE (in years lost birthday) 43		31. BIRTHPLACE (State or foreign country) Maryland		32. CITIZEN OF WHAT COUNTRY?	
33. FATHER'S NAME Boswell Walter		34. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preaching Agent		35. MOTHER'S MAIDEN NAME Ruth Knight		36. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 2	
37. SOCIAL SECURITY NO. 290-14-7851		38. INFORMANT Bessie Walter		39. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		40. DATE OF OPERATION 2	
41. ANATOMY? (Yes or No) yes		42. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		43. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		44. LOCATION (City, town, or county) (State) Ellicott City Md	
45. DATE REC'D BY HEALTH DEPT. JUL 6 1970		46. NAME OF REGISTRAR Robert E. Fisher		47. FUNERAL DIRECTOR Higginbottom-Slack		48. ADDRESS Ellicott City Md	

FUNERAL DIRECTOR: IMPORTANT

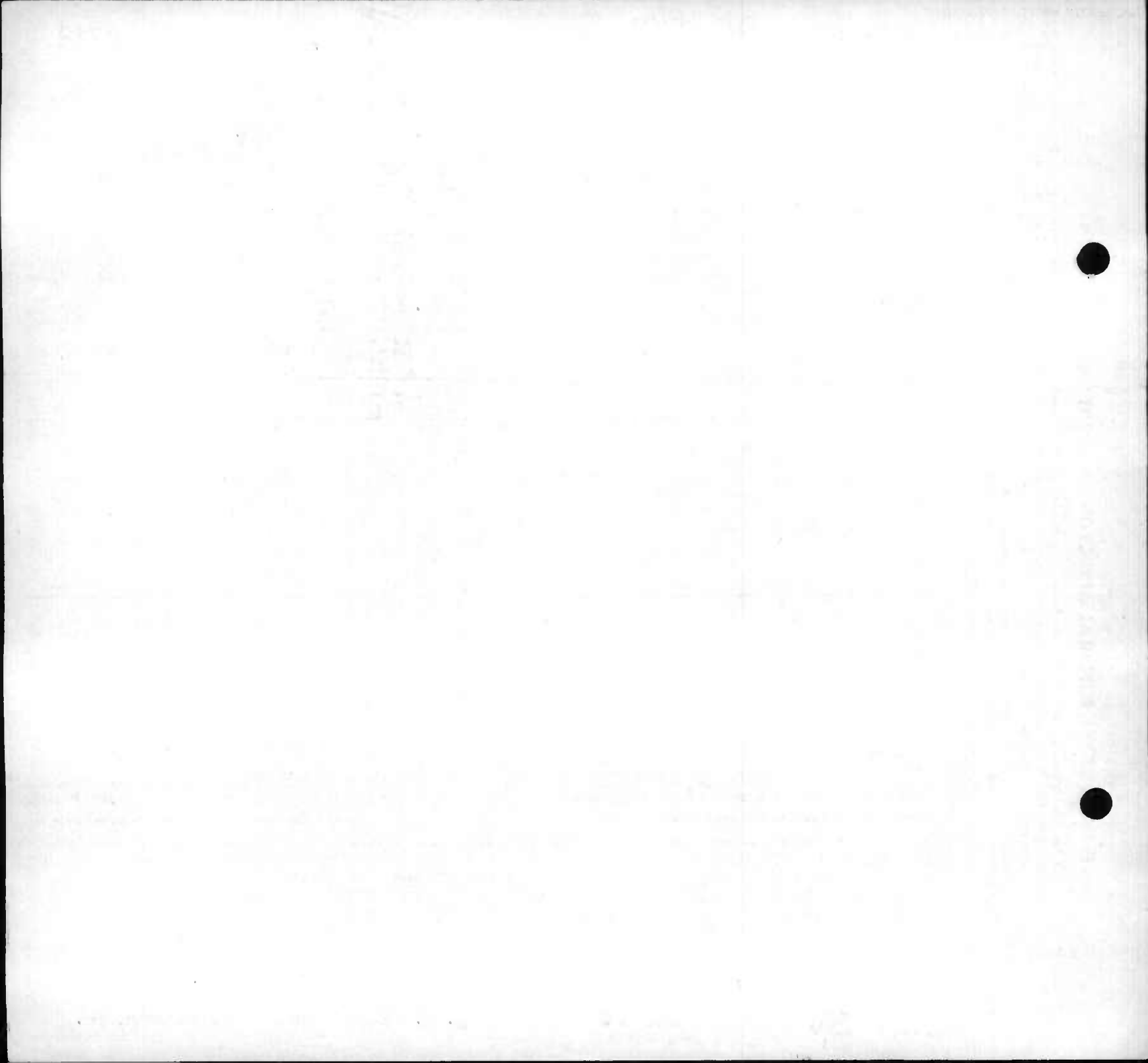
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-500		70 6711		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 6711	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DANA LORETTA J. DANA DANA LORETTA J				2. DATE AND HOUR OF DEATH 7/2/70 12 20 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MASS. B. COUNTY V-18			
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSP.						C. CITY OR TOWN CHELSEA D. INSIDE CITY LIMITS BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						E. STREET AND NUMBER 425 Eastern Ave. 19 WYNCREST AVE. 21228			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-24-98	9. AGE (in years last birthday) 71	10. If Under 1 Yr. Months: 6 Days: 7		11. If Under 24 Hrs. Hours: 7 Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Switchboard Operator US Gov.				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES E. DONOVAN				14. MOTHER'S MAIDEN NAME ELIZABETH CAMPBELL		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none			
16. SOCIAL SECURITY NO. 010-03-6456				17. INFORMANT ADDRESS Mrs. Jacqueline Walsh 19 Wyncrest Av					
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia, left and right lower lobes of lungs				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Anteriosclerotic Heart disease with congestive heart failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cachexia + Malnutrition				(B) DUE TO, OR AS A CONSEQUENCE OF years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cachexia + Malnutrition									
19A. DATE OF OPERATION 2 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 6-22 19 70 to 7-2 19 70 that (1) (we) last saw the deceased alive on 7-2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Sam B. Kerr MB ChB				23B. DATE SIGNED 7-2-70		23C. PHYSICIAN'S NAME (Type) IAIN C. KERR M.B. ChB			
23D. ADDRESS BON SECOURS HOSP 2025 W FAYETTE ST BALTO #23									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 6, 1970		24C. NAME OF CEMETERY or CREMATORY Holy Hood Cemetery		24D. LOCATION (City, town, or county) Brookline, Mass.		24E. STATE Mass.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Funeral Estate 756 Edmondson Ave Catonsville, Md. 21228		25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

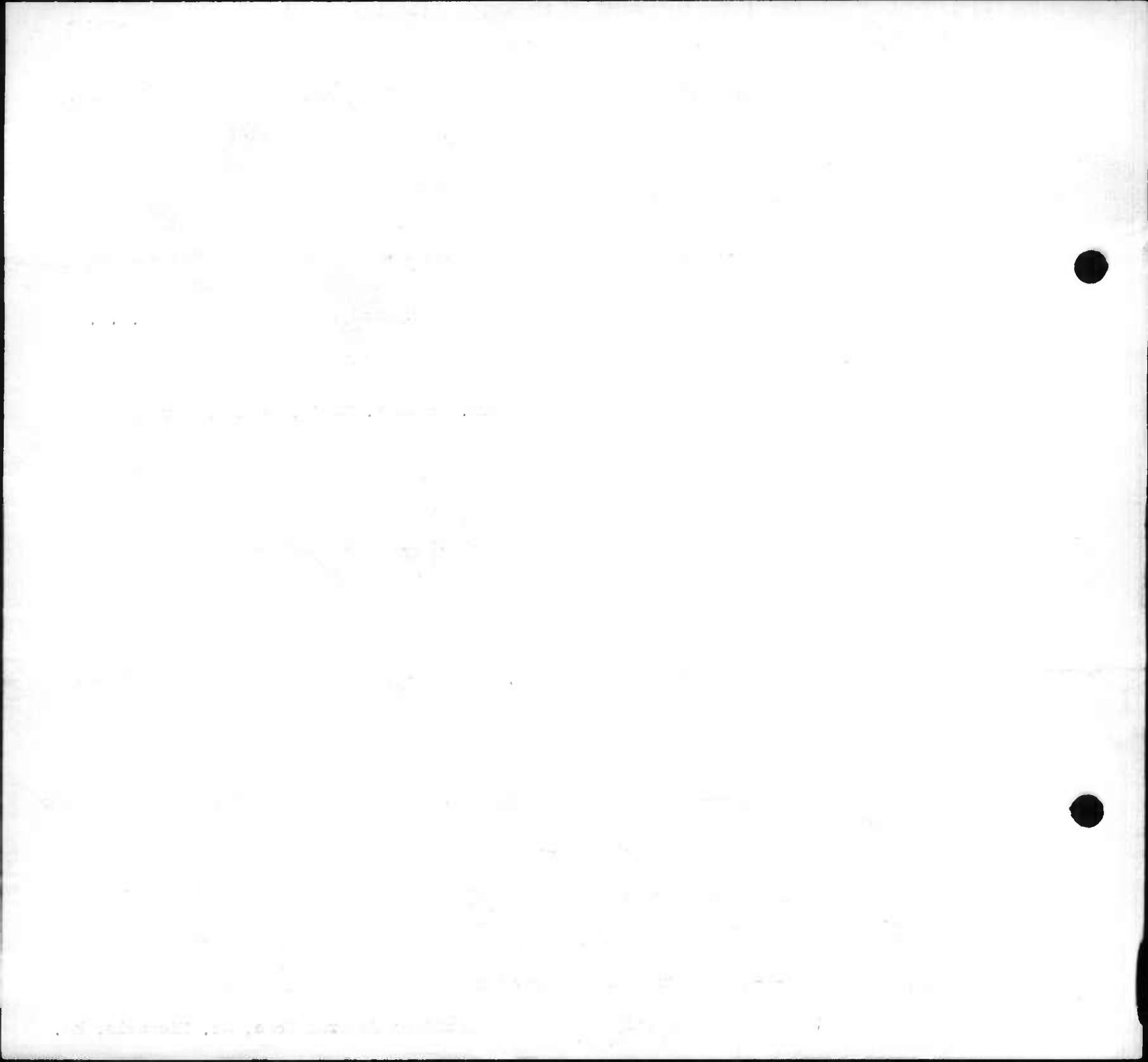
BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
REG. NO. 70 6712											
P-626 70 6712		BIRTH NO. 70-10486		1. NAME OF DECEASED (Type or Print) BABY BOY PARKER				2. DATE AND HOUR OF DEATH 6/29/70 11:45 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.				53-00			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF 42 BALTIMORE				CITY OR TOWN Owings Mills				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER Garrison Forest Road				5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 6/28/70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY				9. AGE (In years lost birthday) 29			
11. BIRTHPLACE (State or foreign country) Balto. City				12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME JAMES Parker			
14. MOTHER'S MAIDEN NAME MARLENE HANNA				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT JORGE SRABSTEIN				ADDRESS SINAI HOSP.				18. 746.9 I CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) HEART FAILURE				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CONGENITAL HEART DISEASE				(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/29/70 6:19 AM to 6/29/70 11:45 AM that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE J. E. Elmer				23B. DATE SIGNED 6/29/70				23C. PHYSICIAN'S NAME (Type) SRABSTEIN, JORGE MD			
23D. ADDRESS SINAI HOSPITAL				23E. PHYSICIAN'S DEGREE				23F. PHYSICIAN'S DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE July 2, 70				24C. NAME OF CEMETERY OR CREMATORY Finksburg Methodist			
24D. LOCATION Finksburg, Md.				24E. LOCATION Finksburg, Md.				24F. LOCATION Finksburg, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970				25B. NAME OF REGISTRAR Robert E. Fisher MD				25C. FUNERAL DIRECTOR B. E. Elmer & Sons			
25D. ADDRESS Reisterstown, Md.				25E. ADDRESS Reisterstown, Md.				25F. ADDRESS Reisterstown, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6713	
BIRTH NO. <u>Talbot, 70 6713</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Lewis, Elton M</u>		2. DATE AND HOUR OF DEATH <u>7/1/70</u> <u>7:00 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3 The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Jalbot, 70-29</u>			
		C. CITY OR TOWN <u>Easton</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>706 S. Washington Street</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/65</u>	9. AGE (in years last birthday) <u>5</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Frank B. Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Mason</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Ethel M. Lewis, Easton, Maryland</u>	
18. <u>03891</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiovascular Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>overwhelming Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> 19 <u>70</u> to <u>7/1</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7/1</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>Ray W. Pettigrew M.D.</u>		23B. DATE SIGNED <u>7/1/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Ray W. Pettigrew M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>7-2-1970</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>	
		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>	
		25B. NAME OF REGISTRAR <u>Robert E. Talbot</u>		25C. FUNERAL DIRECTOR <u>Harrison Funeral Home, St. Michaels, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6714	
P-362 70 6714		CERTIFICATE OF DEATH	
BIRTH NO. P-362		1. NAME OF DECEASED (Type or Print) JOSEPH GEORGE PETRASKA	
2. DATE AND HOUR OF DEATH June 30, 1970		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1607 ELMTREE ST.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 2505	
5. SEX MALE		6. RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28, 1895	
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Anthony Petroska		14. MOTHER'S MAIDEN NAME Anna Petroska	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Coronary occlusion (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A-SHA Dis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 yrs			
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-24-1955 to 6-30-1970 , that (I) (we) last saw the deceased alive on Apr 1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Julius M. Waghelstein		23B. DATE SIGNED 7-1-70	
23C. PHYSICIAN'S NAME (Type) Julius M. Waghelstein		23D. ADDRESS 1010 SP Pearl St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-70	
24C. NAME OF CEMETERY or CREMATORY Holy Cross Cem.		24D. LOCATION (City, town, or county) (State) BALTO. 21225, MD	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR John H. Hahn		ADDRESS 4200 PENNINGTON AVE.	

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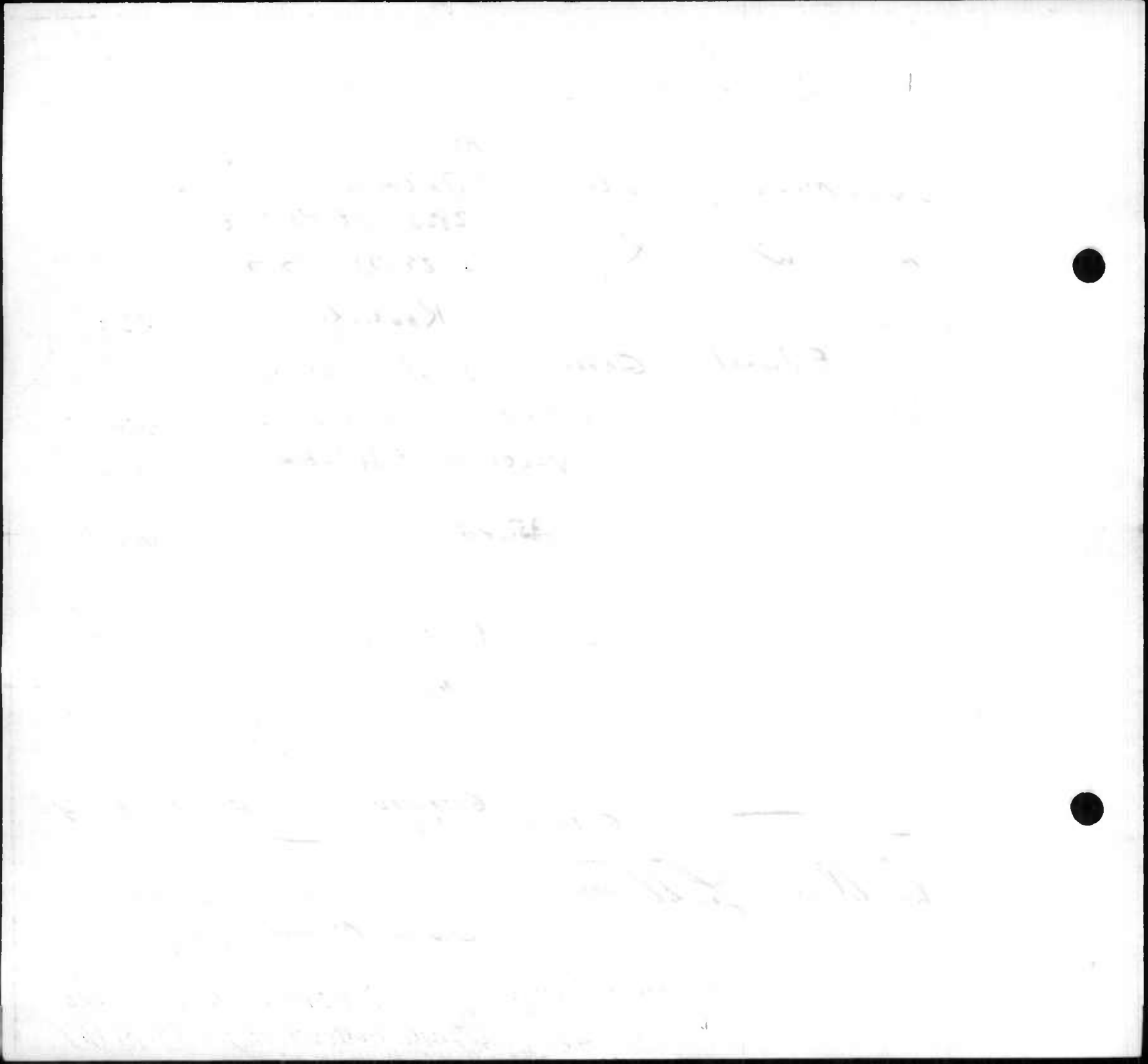
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650		70 6715		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6715	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Robert B Green				2. DATE AND HOUR OF DEATH 6/29/70 12:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 1206			
5. SEX m		6. RACE w		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/29/93	
9. AGE (in years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Green				14. MOTHER'S MAIDEN NAME Augusta Euker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 213 03 4401		17. INFORMANT Robert B Green Jr 1602 Ruxton Ct			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/12/41 VENTRICULAR FIBRILLATION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ASCVD				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). URINARY TRACT INFECTION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/17/70 19 to 6/29/1970 that (I) (we) last saw the deceased alive on 6/29/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 6/29/70		23C. PHYSICIAN'S NAME (Type) [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-1-70		24C. NAME of CEMETERY or CREMATORY Druid Ridge	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970				25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR [Signature] ADDRESS [Signature]	



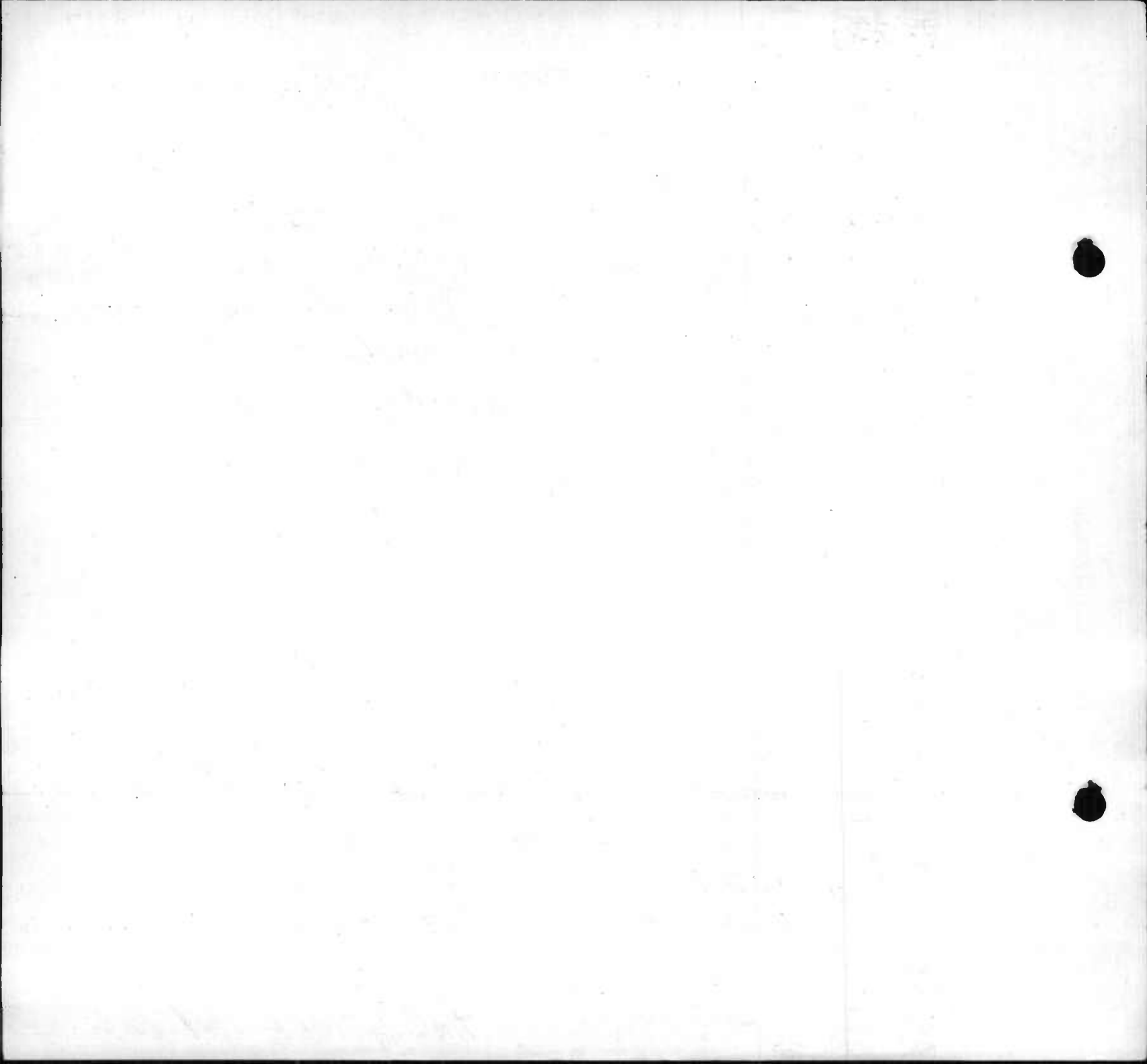
BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
BIRTH NO. <u>C-200 70 6716</u>					REG. NO. <u>70 6716</u>				
1. NAME OF DECEASED (Type or Print) <u>Julia Anna A. Cook</u>					2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month <u>6</u> Day <u>28</u> Year <u>70</u> Hour <u>3:55</u> P.M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>43 So. Baltimore Gen.</u>					3. DATE PRONOUNCED DEAD Month <u>6</u> Day <u>28</u> Year <u>70</u> Hour <u>3:55</u> P.M.				
					5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2534</u>				
6. SEX <u>female</u>		7. RACE <u>White</u>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>Aug. 14, 1891</u>			10. AGE (in years lost birthday) <u>78</u>		11 Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <u>13 Brestd Ave.</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Ellinghaus</u> XXXXXXXXXXXXXXXXXXXX				
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			14B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		15. MOTHER'S MAIDEN NAME <u>Eva Hager</u>				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			17. SOCIAL SECURITY NO. <u>601 11 1111</u>		18. INFORMANT ADDRESS <u>C. Bernard Ellinghaus</u>				
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					Multiple injuries				
					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C) DUE TO, OR AS A CONSEQUENCE OF:				
20A. DATE OF OPERATION <u>2</u>					20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>street</u>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>So. Cross walk at Pottee and Tolbott</u>		
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <u>2:40p</u>			22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Subj. was pedestrian crossing street.</u>				
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Peter Lipkovic, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Peter Lipkovic, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/29/70</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/1/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George J. Gonca 4001 Ritchie Hgy. Baltimore, Md. 21225</u>				

Bristol Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

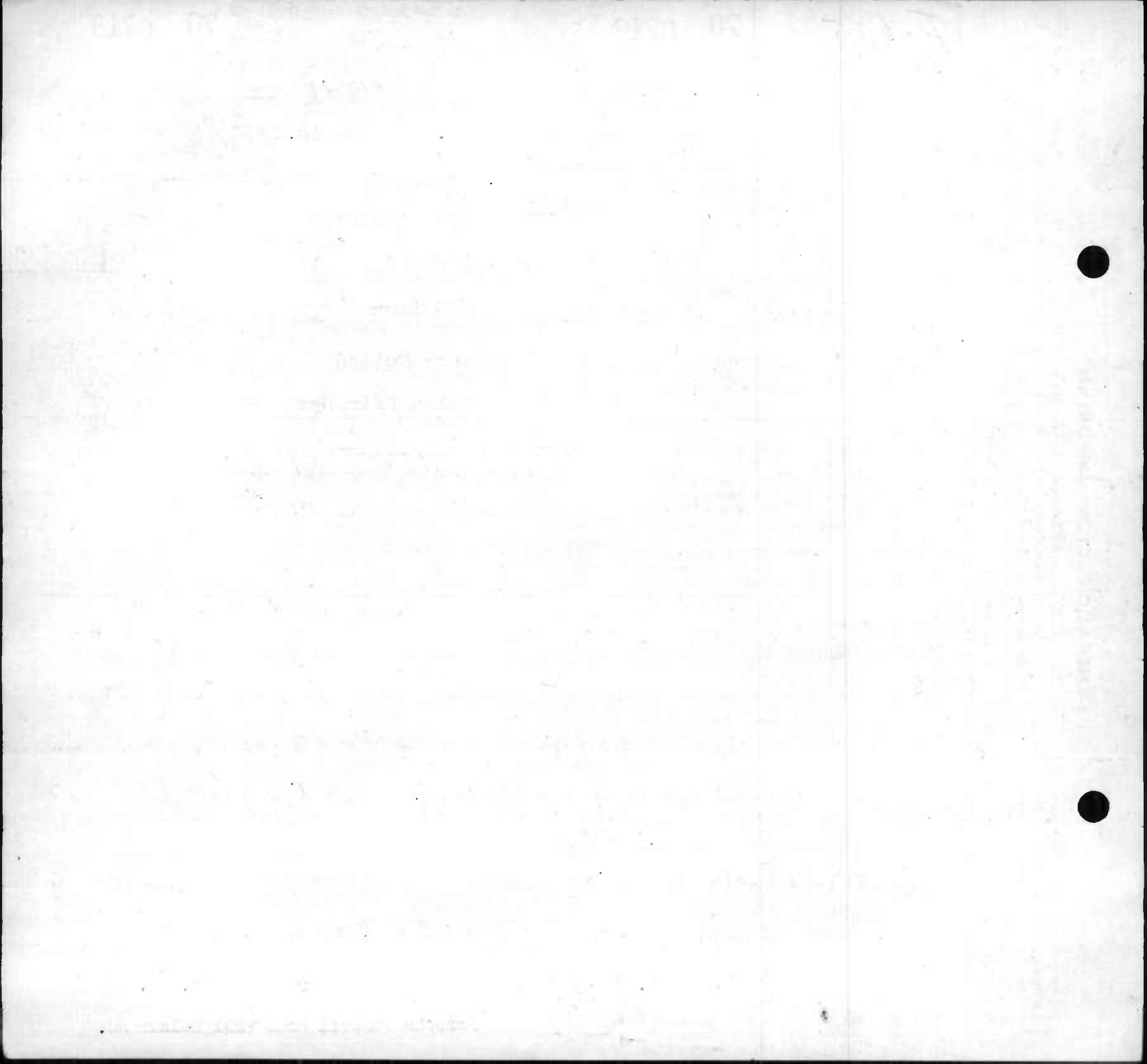
T-520		70 6717		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6717	
BIRTH NO. 1				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Mary Frances THOMAS</i>				2. DATE AND HOUR OF DEATH <i>July 2, 1970 6:30 A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>0113 E. Barney Street Baltimore Md. 21230</i>				A. STATE <i>MD.</i>		B. COUNTY <i>2404</i>	
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>113 E. Barney Street</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 7, 1889</i>	9. AGE (In years last birthday) <i>80</i>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Philadelphia, Pa.</i>	
13. FATHER'S NAME <i>Robert Thomas Jenkins</i>				14. MOTHER'S MAIDEN NAME <i>Martha Ann Year</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>213-54-0041</i>		17. INFORMANT <i>Daughter: Mrs. Gladys Kelm</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic C.V. disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>none</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>-</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <i>-</i>		21F. HOW DID INJURY OCCUR? <i>-</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>Feb. 28</i> 19 <i>56</i> to <i>July 2</i> 19 <i>70</i> , that (I) (we) last saw the deceased alive on <i>July 1</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>C. C. Chiu</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>July 2, 1970</i>	
23C. PHYSICIAN'S NAME (Type) <i>C. C. CHIU M.D.</i>				23D. ADDRESS <i>1 E. Randall St. Balto. Md. 21230</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-6-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE RECD BY HEALTH DEPT. <i>JUL 6 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Talley</i>		25C. FUNERAL DIRECTOR <i>McCully</i>		ADDRESS <i>130 E. Fort Ave.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. F-625 70 6718				BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 6718	
1. NAME OF DECEASED (Type or Print) Andrew J. Friesner				2. DATE AND HOUR OF DEATH 6/25/70 M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 5300					
FULL NAME OF HOSPITAL OR INSTITUTION 45 Good Samaritan Hospital Loch Raven Boulevard Baltimore, Maryland 21212				C. CITY OR TOWN Perry Hall		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 9807 Gunforge Road				5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager				10B. KIND OF BUSINESS OR INDUSTRY Western Mills		8. DATE OF BIRTH 10/3/14		9. AGE (In years last birthday) 55	
11. BIRTHPLACE (State or foreign country) Baltimore Md				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Mitchall Friesner				14. MOTHER'S MAIDEN NAME Anna Toland					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 216074319		17. INFORMANT Helen Friesner		ADDRESS same	
18. 425X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) cardiac myopathy of unknown etiology				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiac myopathy of unknown etiology (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____					
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED YES		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from May 6 19 70 to June 25 19 70 , that (I) (we) last saw the deceased alive on June 25 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Matthew Pollack MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED June 25 1970			
23C. PHYSICIAN'S NAME (Type) Matthew Pollack, M.D.				23D. ADDRESS The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6/29/70		24C. NAME OF CEMETERY or CREMATORY St. Josephs Cem		24D. LOCATION (City, town, or county) (State) Fullerton Balto. Co. Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Rd.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

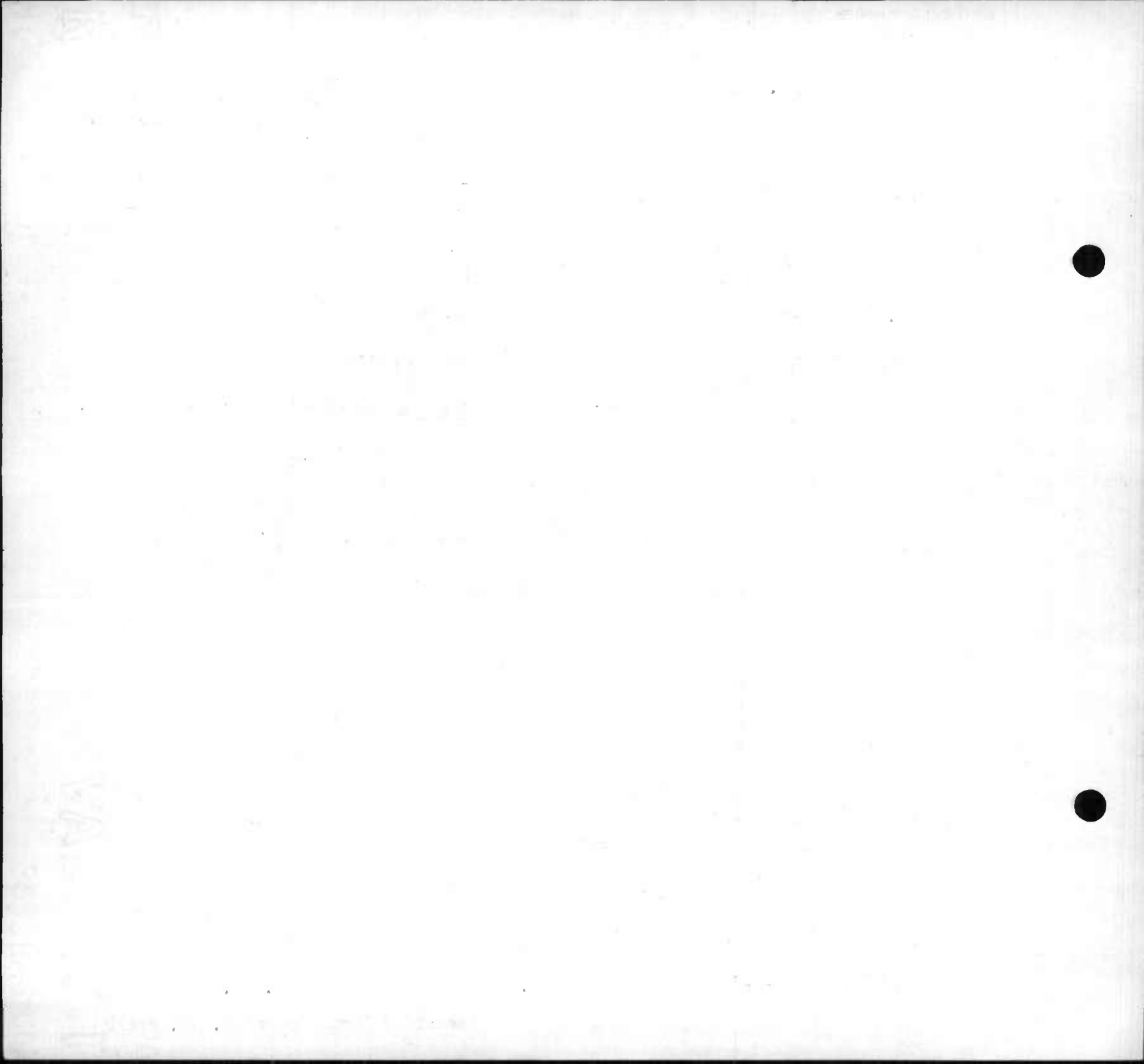
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 70 6719	
BIRTH NO. H-252 M.E. CASE NO. 70 6719		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HIGGINS, CATHERINE M.		2. DATE AND HOUR OF DEATH 7-1-70 10:30 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. Maryland B. COUNTY 2731			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY			
		D. STREET ADDRESS (If rural, give location) 3124 XXXXXXX Burkshire Rd. 21214			
5. SEX 77 F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married XXXXXX	8. DATE OF BIRTH 7/31/42	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife XXXX		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) XXXX Maryland	
12. CITIZEN OF WHAT COUNTRY? XXXX USA		13. FATHER'S NAME FREDERICK M. DEER			
14. MOTHER'S MAIDEN NAME MARGARET E. BERT		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 219-30-5352 B		17. INFORMANT William D Higgins 3124 Burkshire Rd. 21214			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> INTERVAL BETWEEN ONSET AND DEATH (A) Cerebral anoxia, Septicemia 10 days (B) CVA 15 days (C) </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cancer of colon, mouth, lungs					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/13 19 70 to 7/1 19 70 , that (I) (we) last saw the deceased alive on 7/1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Reizo Tsukamoto				23B. DATE SIGNED 7/1/70	
23C. PHYSICIAN'S NAME (Type) Reizo Tsukamoto				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-70		24C. NAME OF CEMETERY or CREMATORY Balto. Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970 Robert E. Fisher, M.D.			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Balto. Md. 21214			

Berkshire Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6720
7-655 70 6720		CERTIFICATE OF DEATH		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) HARRY F. Foreman		7/1/70 12 NOON M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Century Home		A. STATE Md. B. COUNTY 402		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90102 N. Paca St		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		E. STREET AND NUMBER 102 N. Paca St		
6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 8/15/84		9. AGE (In years last birthday) 85		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter		11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frank Foreman		14. MOTHER'S MAIDEN NAME Sarah Wallace		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-6851 A		
17. INFORMANT		ADDRESS		
18. 412.4 I		Mrs Gladys Madich 2911 Sarah Lane 21234		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cardiorespiratory Failure DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CHD (B) Gen & Congenital Abnormalities DUE TO, OR AS A CONSEQUENCE OF: (C) Senility		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.				
23A. SIGNATURE William D Appleford				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) William D Appleford				23D. ADDRESS 6615 Reisterstown Rd
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-70		24C. NAME of CEMETERY or CREMATORY Parkwood Cem.
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J Ruck Inc Balto. Md. 21214		



BIRTH NO.		70 6721		BALTIMORE CITY HEALTH DEPARTMENT		70 6721	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) PAUL MARSH				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month July Day 1 Year 1970 Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital (DOA)				3. DATE PRONOUNCED DEAD Month July Day 1 Year 1970 7:20 P.M.			
6. SEX Male				5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2744			
7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH June 10, 1911		10. AGE (In years last birthday) 58 59		E. STREET AND NUMBER Bertrum Ave. 5932 EXXORIAN AVENUE			
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clarence R Marsh			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Senior Clerk		14B. KIND OF BUSINESS OR INDUSTRY Balto. City		15. MOTHER'S MAIDEN NAME Winifred E Greene			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 215-01-0621		18. INFORMANT ADDRESS Mrs Katherine V Marsh 5932 Bertrum Ave.			
19. 4/12.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 2, 1970 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-70		24C. NAME of CEMETERY or CREMATORY Woodlawn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Bailey		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Back Inc Balto. Md. 21214			

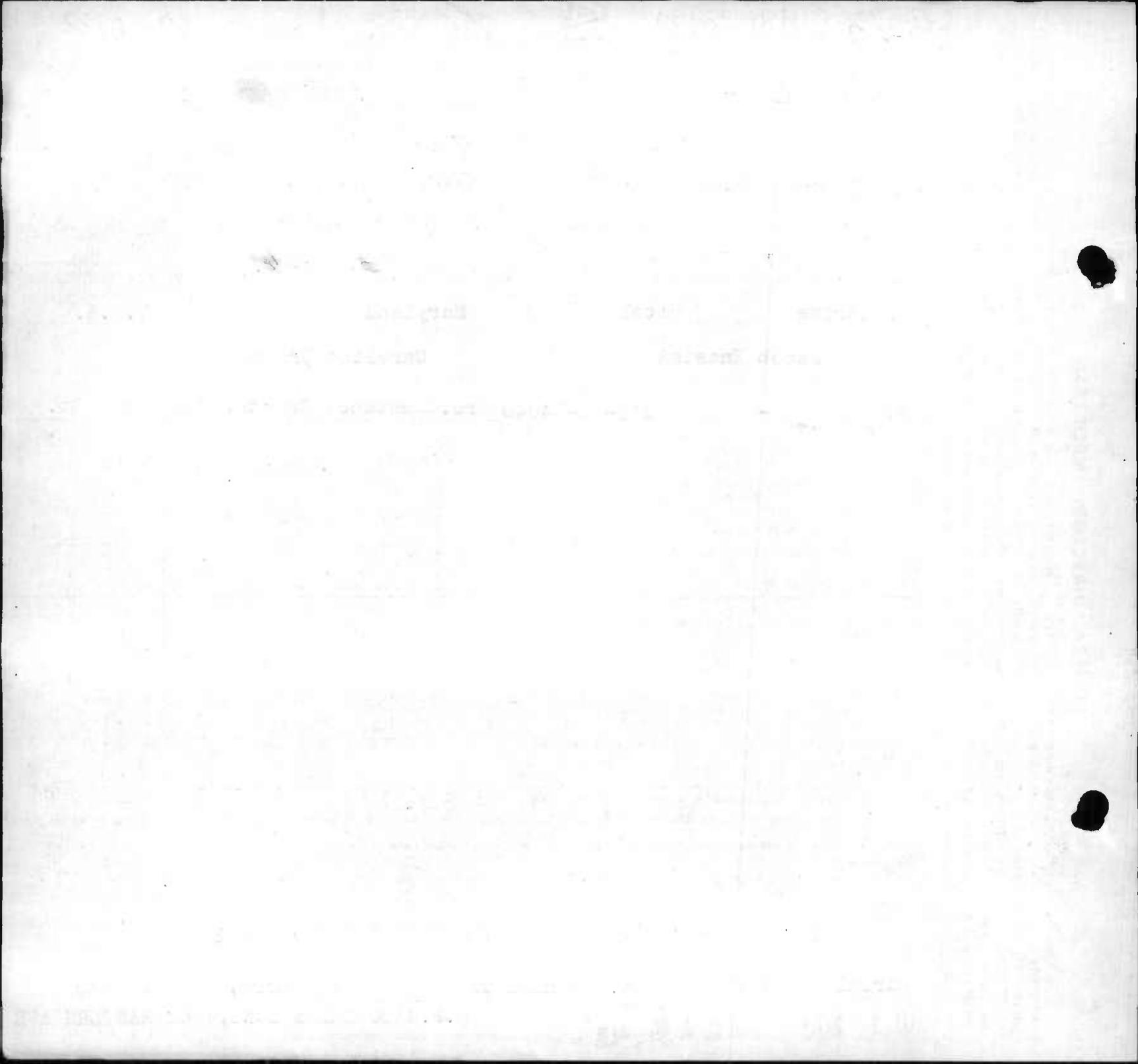
Bertram Ave.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

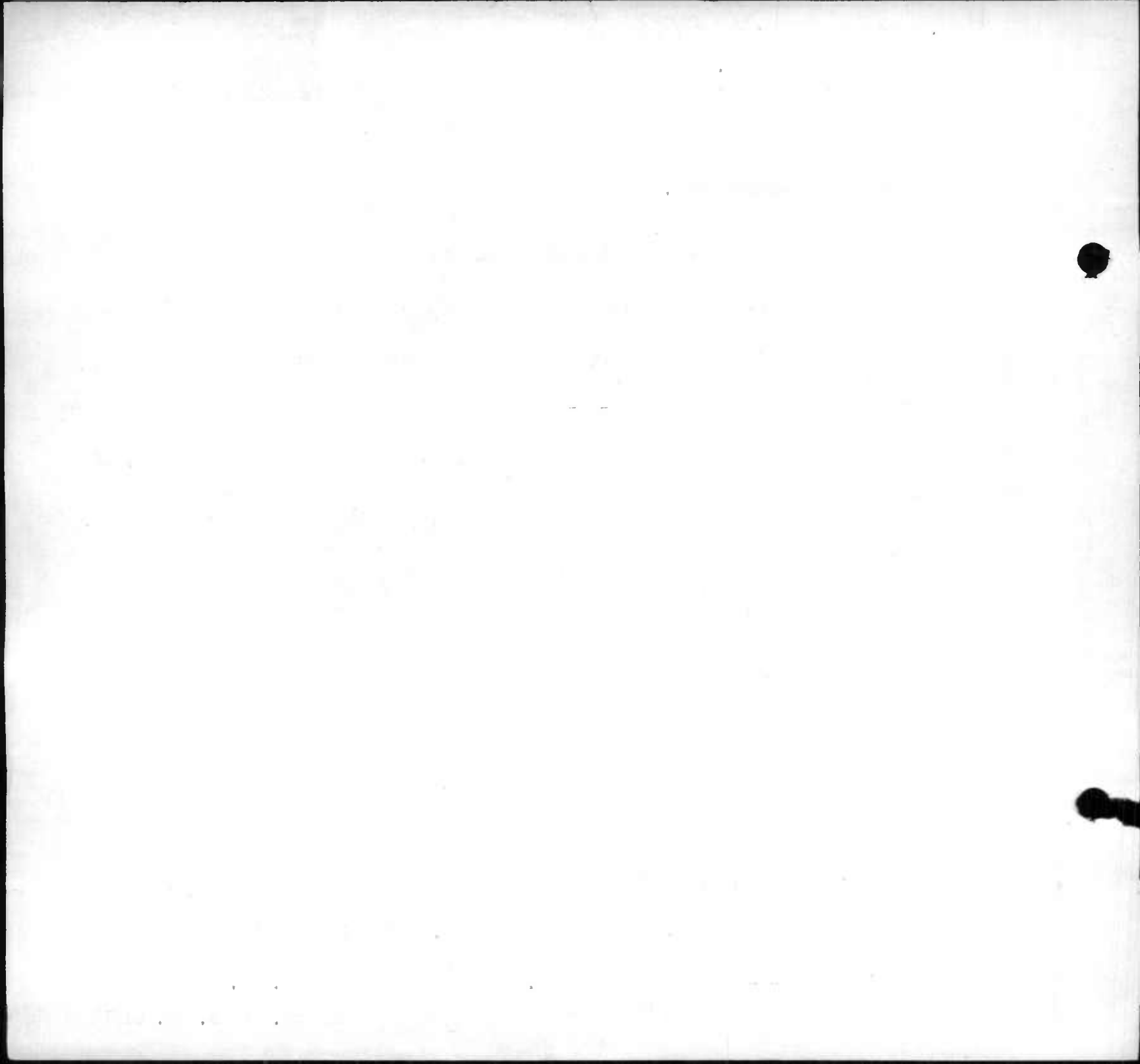
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6722	
B-620 70 6722 CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Rose E. Boracki</i>		2. DATE AND HOUR OF DEATH <i>9-2-70 7:30 4³⁰ A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>202</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Mt. Sinai Nursing Home</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>1733 Gough St.</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-2-03</i>	9. AGE (In years last birthday) <i>66</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Jacob Knasiak</i>			14. MOTHER'S MAIDEN NAME <i>Caroline Drzymala</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-03-0404D</i>		17. INFORMANT <i>Mrs. Constance Brooks, 1735 Gough St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>7/2/31</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebro Vascular Acc.</i> <i>Rheumatoid Arthritis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>5/28/70</i> 19 <i>70</i> to <i>7/3</i> 19 <i>70</i> , that (I) (we) lost saw the deceased alive on <i>7/2</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. S. Kallins</i>				23B. DATE SIGNED <i>7/3/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. S. KALLINS</i>				23D. ADDRESS <i>6000 PARK HTS AVE</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/7/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Stanislaus</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>		25C. FUNERAL DIRECTOR <i>M.F. SADOWSKI & SONS, 1808 EASTERN AVE</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

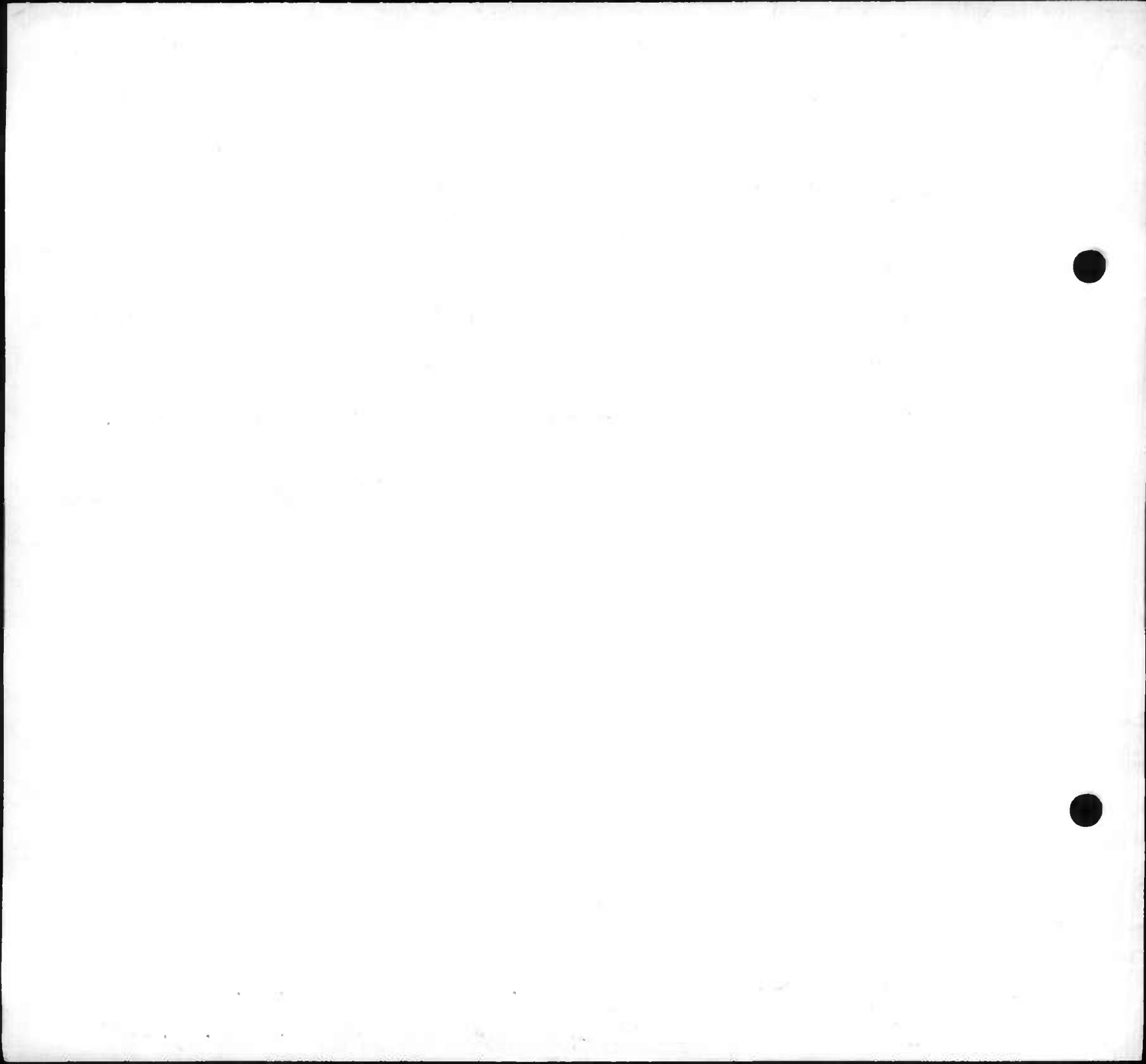
B-653 70 6723		BALTIMORE CITY HEALTH DEPARTMENT		70 6723		
BIRTH NO.		REGISTERED NO.		70 6723		
M.E. CASE NO.						
1. NAME OF DECEASED (Type or Print) Brand Sunie			2. DATE AND HOUR OF DEATH 7/1/70 11:35 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hosp.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2743 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5006 Ross Rd.			
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (specify) Widowed	8. DATE OF BIRTH 12/29/86	9. AGE (In years last birthday) 83	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10B. KIND OF BUSINESS OR INDUSTRY Gutman's		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Dryden			14. MOTHER'S MAIDEN NAME Mary Gibbons			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-01-1879A		17. INFORMANT M's Norma Brand ADDRESS 4408 Mainfield Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 410.915-162.1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Coronary Occlusion (A) DUE TO Coronary Artery Disease (B) Possible pulmonary embolism Other: Bronchogenic Carcinoma PUL Pulmonary infarct		INTERVAL BETWEEN ONSET AND DEATH 2 days 2 months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 6/9 19 70 to 7/1 19 70 , that (I) (we) last saw the deceased alive on 7/1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Reizo Tsukamoto				23B. DATE SIGNED 7/1/70		
23C. PHYSICIAN'S NAME (Type) Reizo Tsukamoto				23D. ADDRESS Maryland General Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-70		24C. NAME OF CEMETERY or CREMATORY Parkwood Cem.		
				24D. LOCATION (City, town, or county) (State) Balto. Md.		
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. ADDRESS Balto. Md. 21214		



FUNERAL DIRECTOR: IMPORTANT

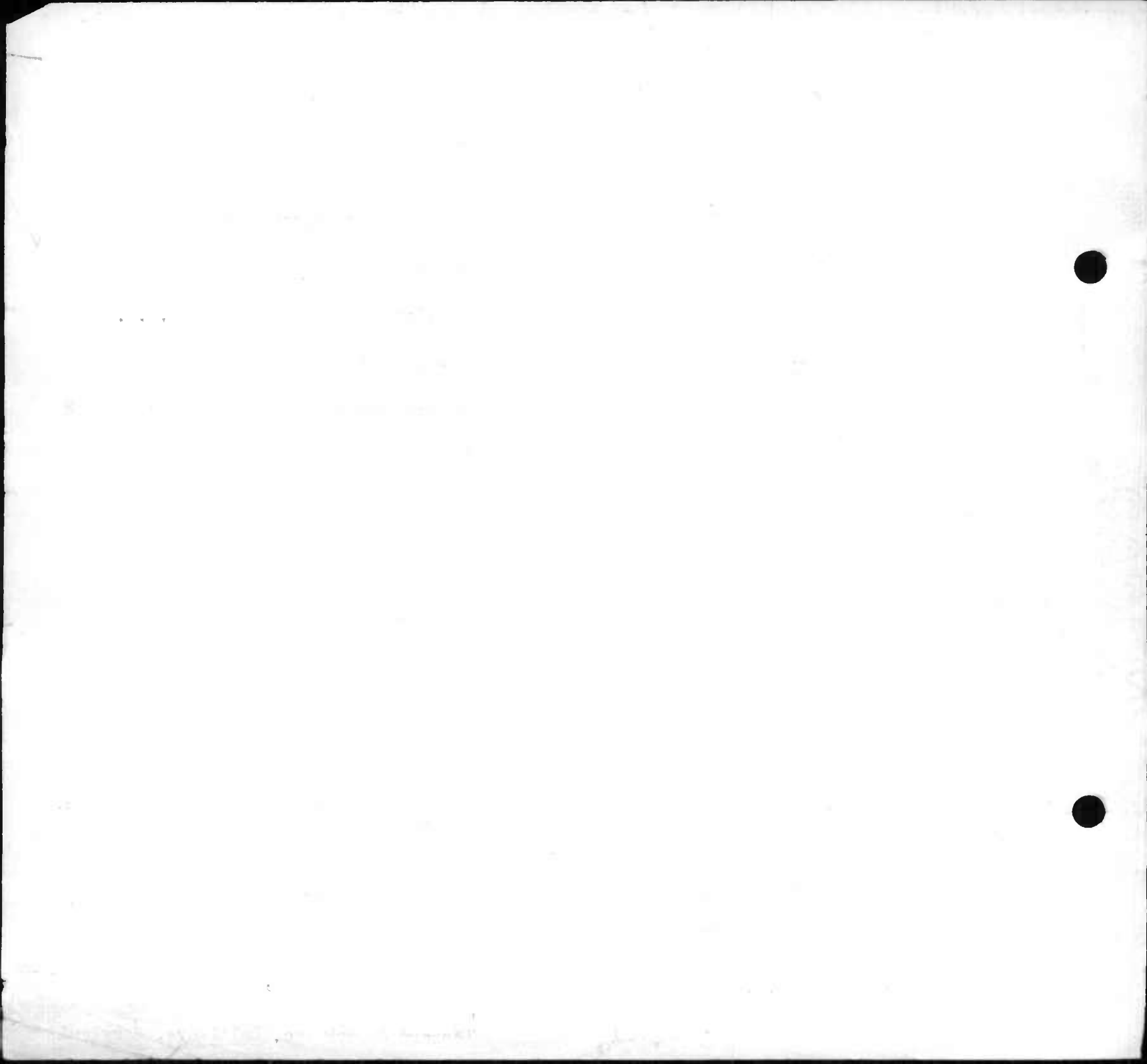
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6724		REG. NO. 70 6724	
BIRTH NO. <u>H-632</u>				70 6724		70 6724	
1. NAME OF DECEASED (Type or Print) <u>MARY E. HARDISTY</u>				2. DATE AND HOUR OF DEATH <u>JULY 2, 1970</u> <u>2:55 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u> <u>44</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2758</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>5816 EDGE PARK ROAD - APT C</u>			
5. SEX <u>Female</u>	6. RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/3/87</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>James Pryor</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>577-05-1857</u>				17. INFORMANT <u>Ellwood T Hardisty 5816 Edgemark Rd. 21214</u>			
18. <u>4/10/91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u> <u>2° to ASCVD.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u> 20A. AUTOPSY? (Yes or No) <u>0</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>0</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4/10/91</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>0</u>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>0</u>				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>0</u>			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? <u>0</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> 19 <u>70</u> to <u>July 2</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>July 2</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>David J. Powner, M.D.</u>				23B. DATE SIGNED <u>July 2, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>0</u>	
23D. ADDRESS <u>0</u>				23E. DEGREE <u>0</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-6-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Com.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Buck Inc.</u>		25D. ADDRESS <u>Balto. Md. 21214</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

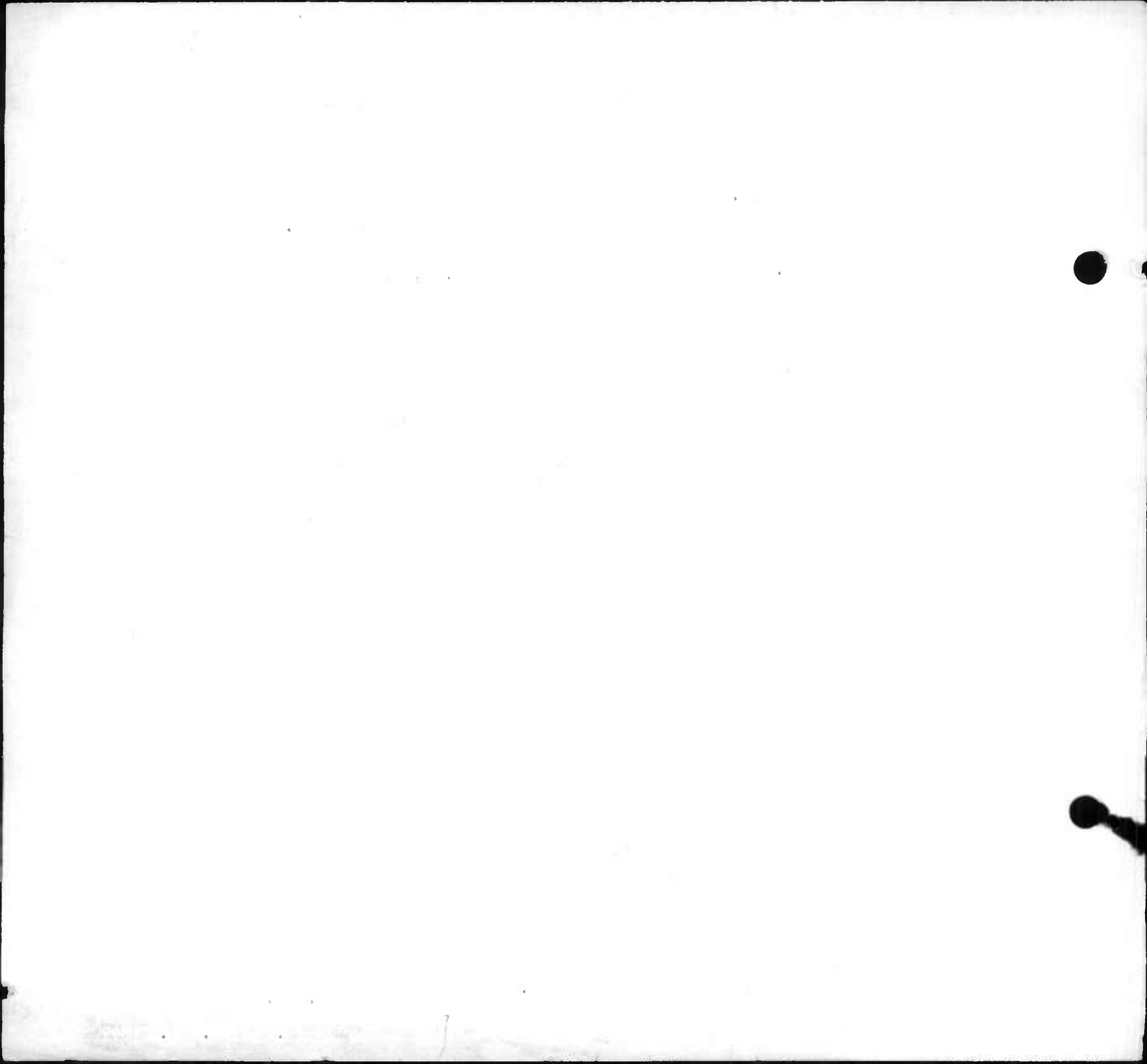
B-324 70 6725		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6725	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lillian Batchelder</i>		2. DATE AND HOUR OF DEATH <i>June 30, 1970 8:30 AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>The Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1002</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>9/5/87</i>		9. AGE (In years last birthday) <i>82</i>		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George Kolb</i>		14. MOTHER'S MAIDEN NAME <i>Mary Goudy</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Mary Henton 1128 Ashland Court 21202</i>	
18. <i>174X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Breast cancer with widespread metastases including cerebral metastases</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Hypertensive cardiovascular disease</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(1) (this hospital)</u> attended the deceased from <u>June 29</u> 19 <u>70</u> to <u>June 30</u> 19 <u>70</u> that <u>(1) (me)</u> last saw the deceased alive on <u>June 30</u> 19 <u>70</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1) (We)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thomas E. Davis, MD</i>		23B. DATE SIGNED <i>June 30, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>Thomas E. Davis, M.D.</i>	
23D. ADDRESS <i>The Johns Hopkins Hospital</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/2/70</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Western</i>		24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(Total)	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, MD</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc.</i>	
				ADDRESS <i>Baltimore, Maryland</i>	



FUNERAL DIRECTOR: IMPORTANT

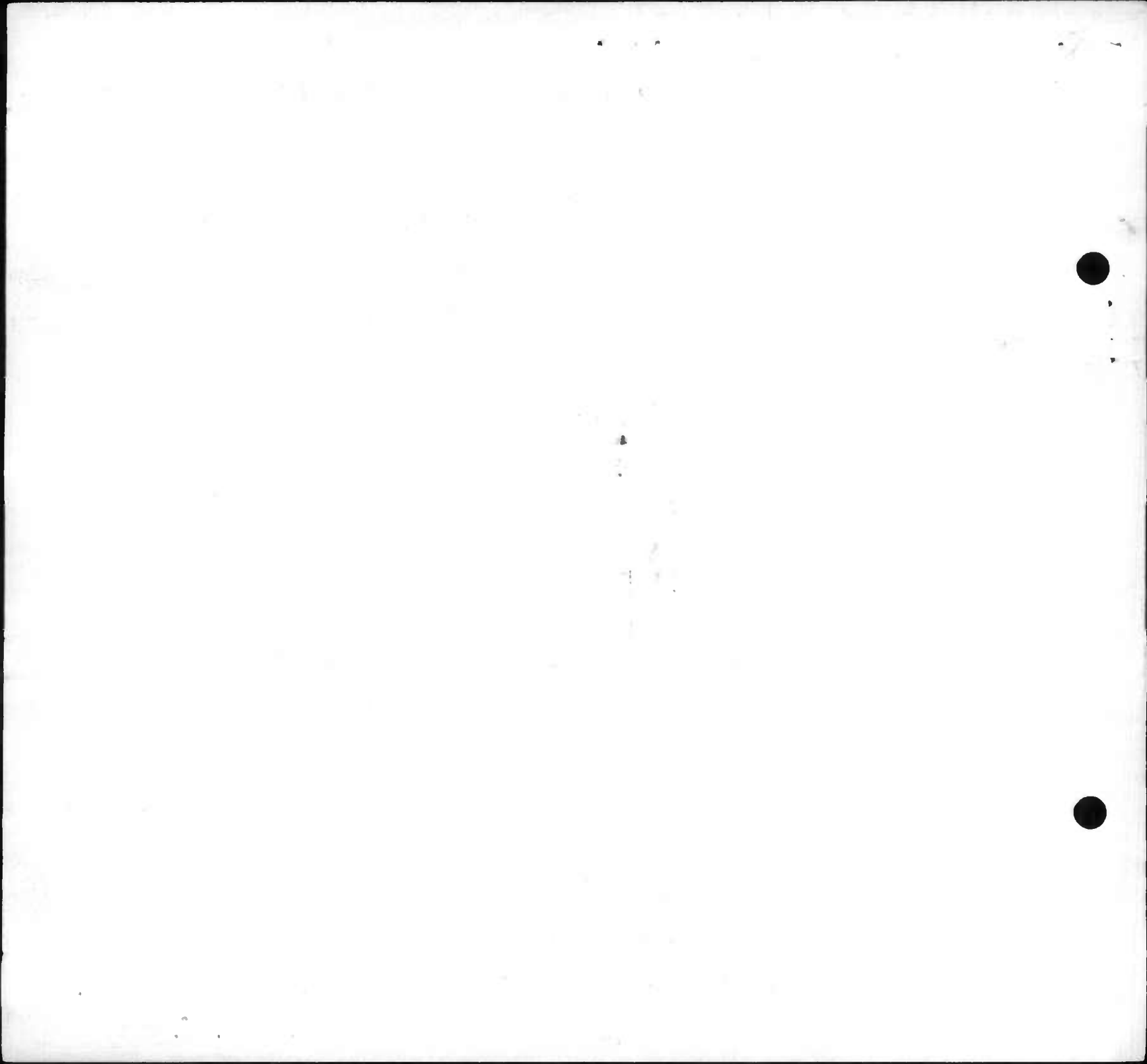
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 6726		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6726	
1. NAME OF DECEASED (Type or Print) Anna Dietel			2. DATE AND HOUR OF DEATH 6-30-70		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2104 Dobler Ave.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 902 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2104 Dobler Ave. 21218		
5. SEX Female	6. RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1885	9. AGE (In years last birthday) 84	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Dietel		14. MOTHER'S MAIDEN NAME Elizabeth Shrader	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Emma Fisher	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral Accidents DUE TO, OR AS A CONSEQUENCE OF: (B) Hypertension C. U. Wm. DUE TO, OR AS A CONSEQUENCE OF: (C) Generalized Atherosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 4 yrs			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 04 to 6/30 19 70 that (I) (we) last saw the deceased alive on 6/23 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leonard J. Ruck			23B. DATE SIGNED 7/1/70		
23C. PHYSICIAN'S NAME (Type) Robert E. Fisher, M.D.			23D. ADDRESS Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-70		24C. NAME of CEMETERY or CREMATORY Parkwood Cem.	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 6 1970			
25A. NAME OF REGISTRAR Robert E. Fisher, M.D.		25B. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

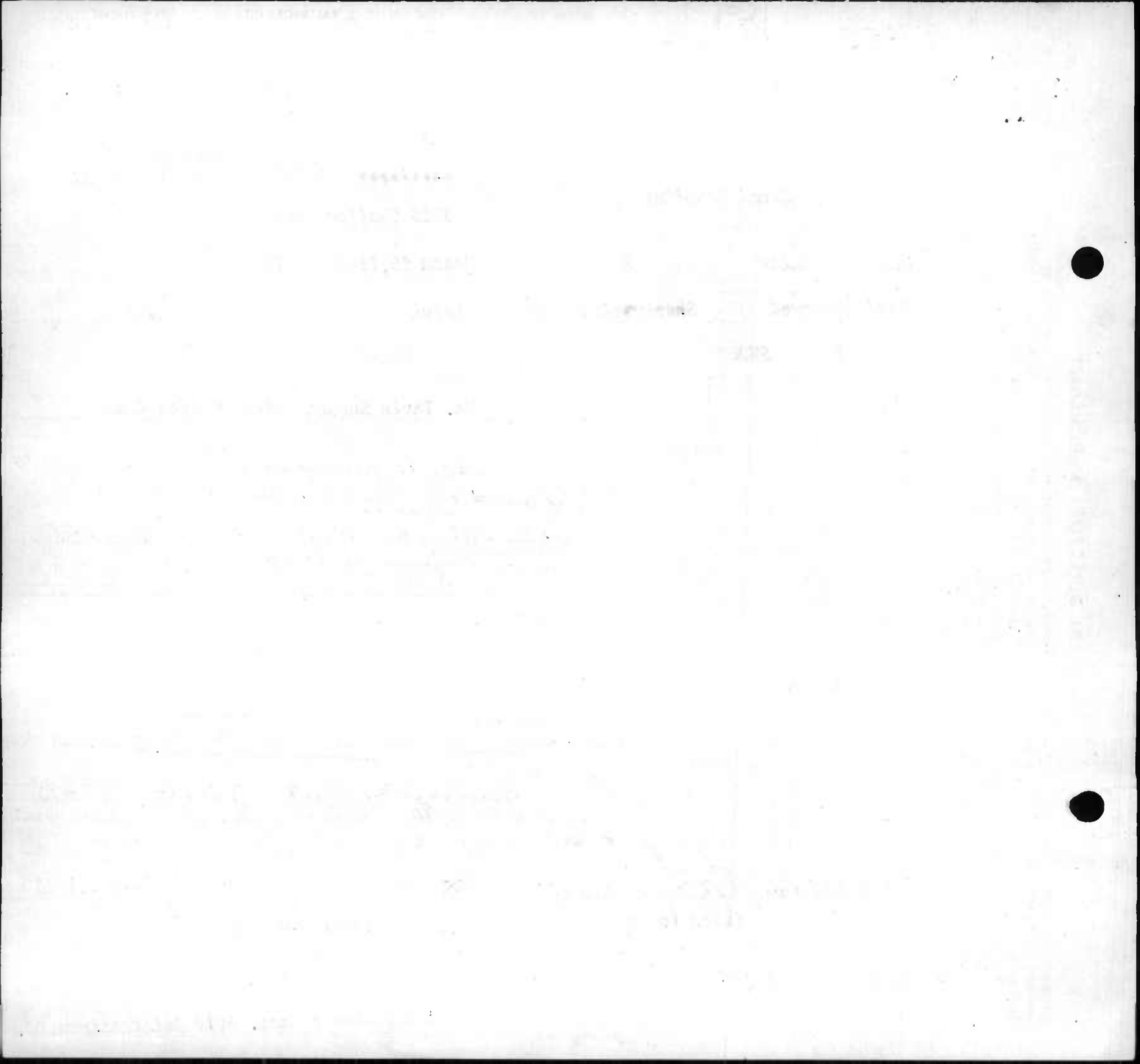
BALTIMORE CITY HEALTH DEPARTMENT				70 6727	
X-322 70 6727				CERTIFICATE OF DEATH X	
BIRTH NO.		REG. NO.		70 6727	
1. NAME OF DECEASED (Type or Print) YUTCHISHEN, JOE			2. DATE AND HOUR OF DEATH July 1st 1970 3.05 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7204 WOODROW AVENUE		
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) AUSTRIA	
13. FATHER'S NAME NOT KNOWN Mike Yutchishen			14. MOTHER'S MAIDEN NAME NOT KNOWN Katherine Timchishen		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 209-07-5910A		17. INFORMANT ADDRESS Mr Frank Yutchishen 7204 Woodrow Ave 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteriorly located Cardiovascular Disease Arteriosclerosis FEVER OF UNKNOWN ORIGIN Fracture of hip 2 MONTHS AGO			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 639 Fenway Ave	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 5-10-70 4:30 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fall	
22. I certify that (I) (this hospital) attended the deceased from JUNE 30 1970 to JULY 1 1970 and that (I) (we) lost saw the deceased alive on July 1 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Miguel Karacuschansky M.D.			23B. DATE SIGNED July 1st 1970		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) Miguel Karacuschansky, M.D.			23D. ADDRESS Union Memorial Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-3-70		24C. NAME OF CEMETERY or CREMATORY Belair Memorial Gardens	
24D. LOCATION Belair, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>S-536</u> <u>70</u> <u>6728</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>70</u> <u>6728</u>	
1. NAME OF DECEASED (Type or Print) <u>David Snyder</u>				2. DATE AND HOUR OF DEATH <u>July 2, 1970</u> <u>5:28 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42</u> <u>Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balto.</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>March 25, 1895</u> 9. AGE (In years last birthday) <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u> 11. BIRTHPLACE (State or foreign country) <u>Latvia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>? SNDR</u> 14. MOTHER'S MAIDEN NAME <u>Hannah ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Irvin Snyder</u> ADDRESS <u>3923 Chaffey Road</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction with pulmonary edema</u> (B) <u>Arteriosclerosis Heart disease with angina pectoris</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>July 2, 1970</u> <u>3 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>							
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? _____ (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____	
21E. INJURY OCCURRED _____ While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____		22. I certify that (I) (this hospital) attended the deceased from <u>March 31, 1967</u> to <u>July 2, 1970</u> , that (I) (we) last saw the deceased alive on <u>July 2, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE <u>Milton E. Lowman</u> DEGREE _____				23B. DATE SIGNED <u>July 2, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Milton Lowman</u>	
23D. ADDRESS <u>1401 Reisterstown Road</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>7/3/1970</u>			
24C. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young Mens</u>				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			
25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros.</u>				ADDRESS <u>6010 Reisterstown Rd.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6729	
L-150 70 6729		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) LEVINE, SAM		1 JULY 1970 7:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Singer Hospital of Baltimore		A. STATE Maryland B. COUNTY Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 3717 Bartwood Ave	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		8. DATE OF BIRTH 8/1/21 9. AGE (in years last birthday) 49	
10B. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) New York, New York	
13. FATHER'S NAME Louis Levine		12. CITIZEN OF WHAT COUNTRY USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ruth Levine		ADDRESS 3717 Bartwood Road #15	
18. 4/10/9 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 28 JUNE 1970 to 1 JULY 1970 that (we) last saw the deceased alive on 1 JULY 1970 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.			
23A. SIGNATURE Morris Ostroff, MD		23B. DATE SIGNED 1 JULY 70	
23C. PHYSICIAN'S NAME (Type) Morris Ostroff, MD		23D. ADDRESS Singer Hospital of Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/70	
24C. NAME OF CEMETERY or CREMATORY Beth Tfiloh		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD	
25C. FUNERAL DIRECTOR Sol Levinson & Bros.		ADDRESS 6010 Reisterstown Road	

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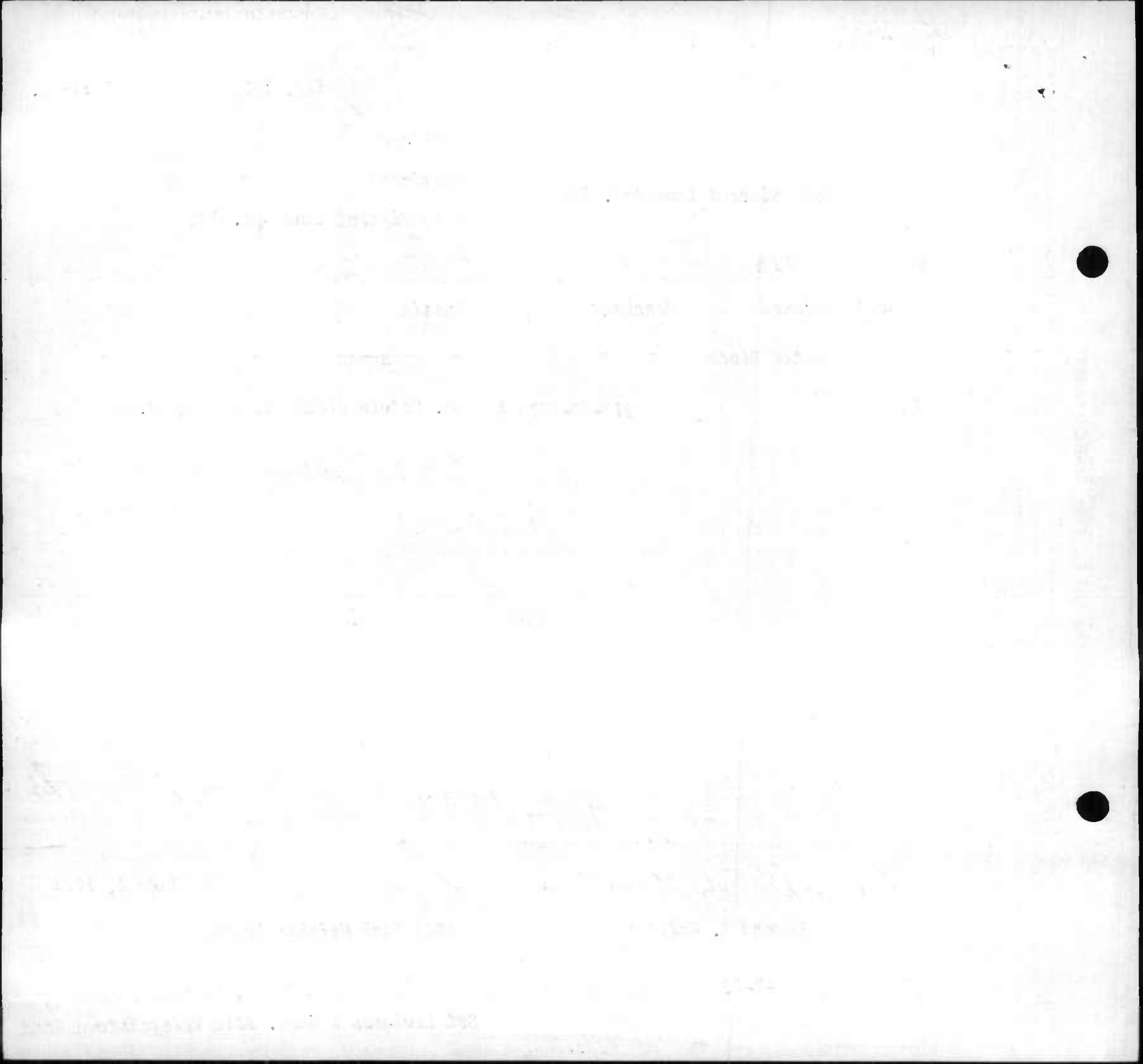
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6730	
B-420 70 6730 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
LOUIS BLOCK		JULY 1st, 1970		12:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
00 6610 Vincent Lane Apt. 102		Maryland 2831			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		6610 Vincent Lane Apt. 102			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Male	White			April 15, 1889 81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
Self Employed		Merchant		81	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Morris Block		Sarah ?		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		219-30-6578 A		Mr. Melvin Block 5804 Rubin Avenue #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 wk	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		5 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II		Osles arthritis		10 yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1939 to 7/1 1970, that (I) (we) lost saw the deceased alive on 7/1/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Edward S. Kallins				July 2, 1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Edward S. Kallins				6000 Park Heights Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-2-70		Mikro Kodesh	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 6 1970		Robert E. Taylor, M.D.		Sol Levinson & Bros. 6010 Reisterstown Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-434 70 6731		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6731	
1. NAME OF DECEASED (Type or Print) <i>Pattell, Sadie</i>		2. DATE AND HOUR OF DEATH <i>1 July 1970 7:20 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Singer Hospital of Baltimore</i>		A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>3610 Clarinith Road</i>					
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/15/1886</i>	9. AGE (In years last birthday) <i>84</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>? Adalman</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO. <i>218-54-3774 J-1</i>		17. INFORMANT ADDRESS <i>Mrs. Edna Rosenthal 3610 Clarinith Rd. #15</i>	
18. <i>431.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Intracerebral Hemorrhage</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month Day Year Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>1 July 1970</i> to <i>1 July 1970</i> that (we) last saw the deceased alive on <i>July 1970</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.					
23A. SIGNATURE <i>Morris Ostroff, M.D.</i>		23B. DATE SIGNED <i>1 July 1970</i>			
23C. PHYSICIAN'S NAME (Type) <i>Morris Ostroff, M.D.</i>		23D. ADDRESS <i>Singer Hospital of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/2/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bobroisker Beneficial Circle</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 6 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Tabor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Sol Levinson & Bros. 6010 Reisterstown Road</i>	

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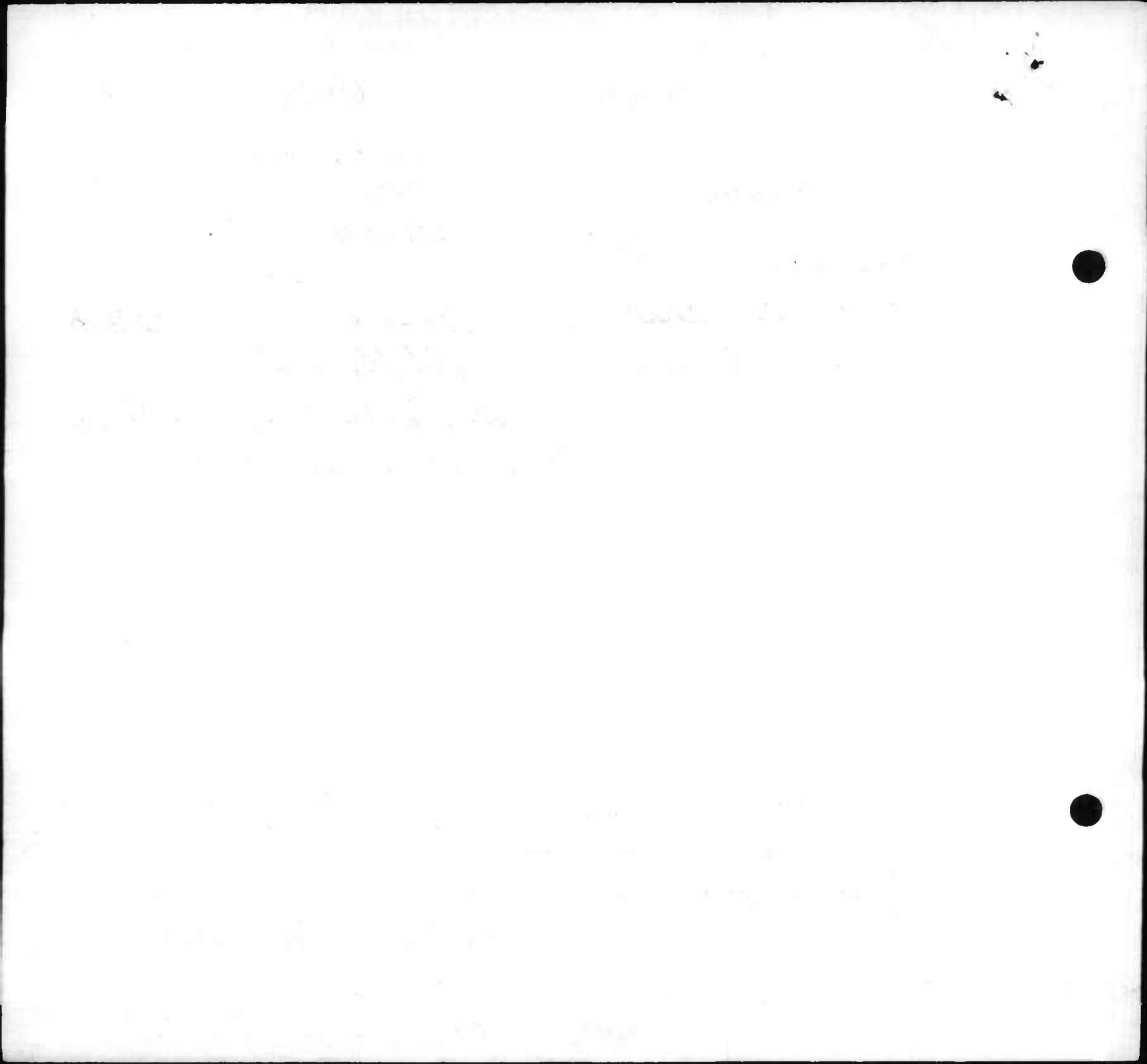
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

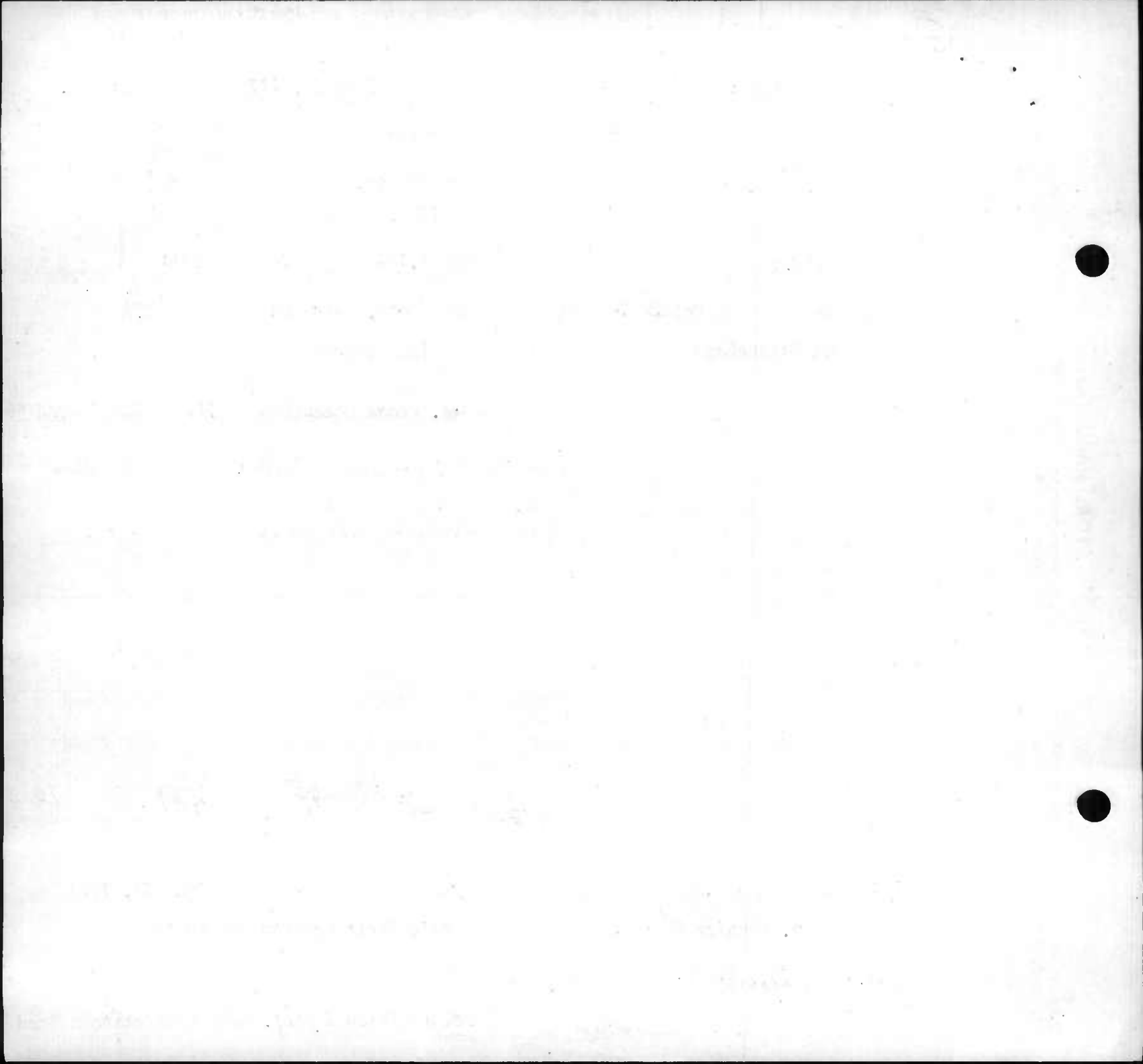
K-656		70 6732		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6732	
1. NAME OF DECEASED (Type or Print) KRAMER, HYMAN				2. DATE AND HOUR OF DEATH 6/30/70 - 5:30 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Baltimore, Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3417 Garrison Farms Rd.					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 76	9. AGE (In years last birthday) 26		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10B. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isidor Kramer				14. MOTHER'S MAIDEN NAME Sheffer		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Dr. Charles Kramer - Same					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Pancreas, Metastatic ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos +	
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 6/11/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EXPLORATORY LAP.		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1955 to June 30 19 70 that (I) (we) last saw the deceased alive on 6/24 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Daniel Bakal MD.				23B. DATE SIGNED 6-30-70		23C. PHYSICIAN'S NAME (Type) DANIEL BAKAL, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/1/70		24C. NAME OF CEMETERY OR CREMATORY Chesapeake American Eng.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. FUNERAL DIRECTOR 6010 Fleet St. Baltimore, Md.		25D. ADDRESS 6010 Fleet St. Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
G-651 70 6733					CERTIFICATE OF DEATH					
BIRTH NO.					REG. NO. 70 6733					
1. NAME OF DECEASED (Type or Print) HARRY GREENEBAUM					2. DATE AND HOUR OF DEATH June 29, 1970 7:30 P.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6113 Benhurst Road					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2730					
					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER 6113 Benhurst Road					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1900	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant			10B. KIND OF BUSINESS OR INDUSTRY Retail Jeweler		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Meyer Greenebaum					14. MOTHER'S MAIDEN NAME Ida Rosenbaum					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Pearl Greenebaum 6113 Benhurst Road #9					
18. 4/10/91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ant rel cv disease					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ant rel cv disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. DATE OF OPERATION none					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 2/7 1965 to 6/29 1970 , that (I) (we) last saw the deceased alive on 6/29 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Maurice Feldman MD					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED June 30, 1970		
23C. PHYSICIAN'S NAME (Type) Dr. Maurice Feldman					23D. ADDRESS 6610 Cross Country Boulevard					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 1, 1970		24C. NAME OF CEMETERY or CREMATORY Baltimore, Hebrew			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			25C. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-536 70 6734		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X 70 6734	
BIRTH NO.		1. NAME OF DECEASED Type of Print Goldie Bantrum		2. DATE AND HOUR OF DEATH July 3, 1970 9:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Hilton Nursing Home 3313 Poplar Street Baltimore, Md. 21216		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Anne Arundle C. CITY OR TOWN Annapolis D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 74 East Street			
5. SEX Female	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1908	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Fred Jennings		14. MOTHER'S MAIDEN NAME Martha Bailey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) III yes, give war or dates of service		16. SOCIAL SECURITY NO. 310-20-0282A		17. INFORMANT ADDRESS Joseph Jennings, Annapolis, Md.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sepsis</i> (B) Extensive decubiti DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Psychosis due to A.S.CVD.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 4-23-1970 to 7-3-1970 that (I) (we) last saw the deceased alive on 7-1-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Barbu Calin</i>		23B. DATE SIGNED 7-3-70		23C. PHYSICIAN'S NAME (Type) BARBU CALIN	
23D. ADDRESS 831 Poplar Grove		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/70	
24C. NAME of CEMETERY or CREMATORY Balto. Natl.		24D. LOCATION Balto., Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 6 1970	
24F. NAME OF REGISTRAR Robert E. Taylor, Md.		24G. FUNERAL DIRECTOR Rose Funeral Home Annapolis, Md.		24H. ADDRESS	

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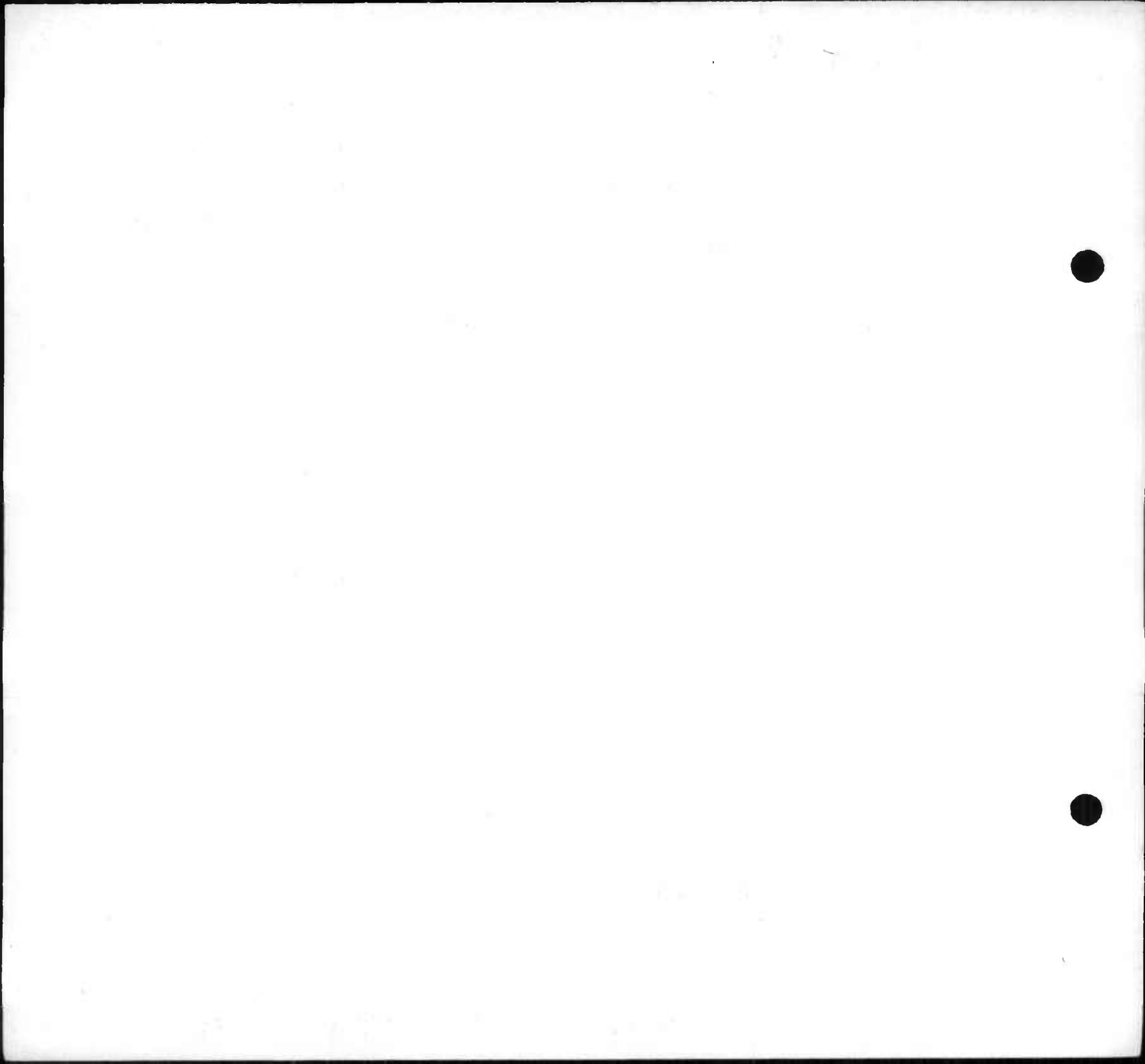
1/1/00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 6735</u>	
G-625 BIRTH NO. <u>Balto. Co 70 6735</u>				2. DATE AND HOUR OF DEATH <u>6/30/70</u> <u>5:00 P.M.</u>			
1. NAME OF DECEASED (Type or Print) <u>GARRISON BB</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> <u>33</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>513 N. Woodward Drive</u>			
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/18/70</u>	9. AGE (In years last birthday) <u>12</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>				10B. KIND OF BUSINESS OR INDUSTRY —		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EVERETT GARRISON</u>				14. MOTHER'S (MAIDEN) NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT ADDRESS			
18. <u>726.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Severe hyaline membrane disease with broncho-pulmonary dysplasia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>and Pneumothorax</u> (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Prematurity</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/18/70</u> to <u>6/30</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6/30</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>David Valle</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> DEGREE		23B. DATE SIGNED <u>6/30/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>DAVID VALLE</u>				23D. ADDRESS <u>Dep. Pediatrics JHH Baltimore Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>7/1/70</u>		24C. NAME OF CEMETERY or CREMATOR <u>Johns Hopkins Hospital</u>		24D. LOCATION (City, town, or county) (State) <u>601 N. Broadway Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS			

HOSPITAL DISPOSAL



G-125 70 6736 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **70 6736**

1. NAME OF DECEASED (Type or Print) BERNARD GIBSON				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month July Day 2 Year 1970 Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OF LOCATION) 1749 Thomas Avenue 7-13-70				3. DATE PRONOUNCED DEAD Month July Day 2 Year 1970 Hour 10:20 A.M.			
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1503				6. SEX Male 7. RACE Negro 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH 11/21/34 10. AGE (In years last birthday) 36 11. BIRTHPLACE (State or foreign country) Baltimore Md				12. CITIZEN OF WHAT COUNTRY? U S A			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W W 2				17. SOCIAL SECURITY NO.			
18. INFORMANT Mrs. Gibson-Gibson, Same ADDRESS Mrs. Gertrude Gibson Same				15. MOTHER'S MAIDEN NAME Gertrude			
19. 493X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) IMMEDIATE CAUSE Bronchial asthma DUE TO, OR AS A CONSEQUENCE OF:			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C)			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				24. DATE 7/8/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24C. NAME OF CEMETERY or CREMATORY Louden Park Natl			
24B. DATE 7/8/70				24D. LOCATION (City, town, or county) (State) Baltimore M			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR 6A 7 Halstead, 1206 W north Ave				25D. ADDRESS			

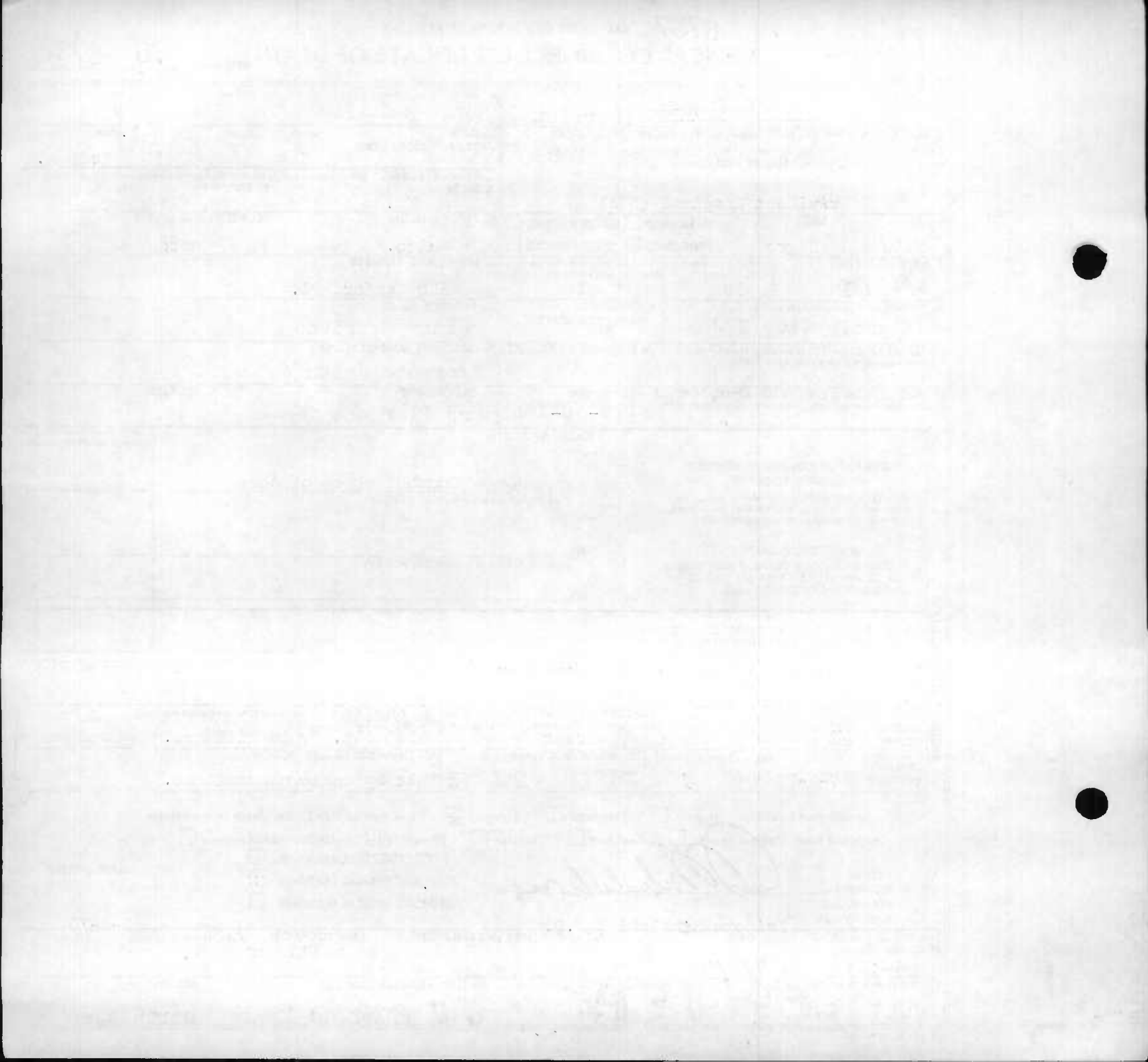
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M-620 70 6737 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 6737

BIRTH NO.

1. NAME OF DECEASED (Type or Print) REGINALD MERRICK (Merritt)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Providence Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour a 4 1970 2:20 A.M.	
6. SEX Male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1403	
9. DATE OF BIRTH 4/13/40		10. AGE (In years last birthday) 30	
11. BIRTHPLACE (State or foreign country) Atlantic City N J		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 213-36-1641	
18. INFORMANT Mrs Florence		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2300 blk. Druid Hill Ave. 1303		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-4-70 7 m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot by unknown assailant.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis M.D. DATE SIGNED 7-4-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/70	
24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT JUL 6 1970		25B. NAME OF REGISTRAR Robert E. [Signature]	
25C. FUNERAL DIRECTOR Halstead		ADDRESS 1206 W north Ave	

VS 151-REV. 1/1/68

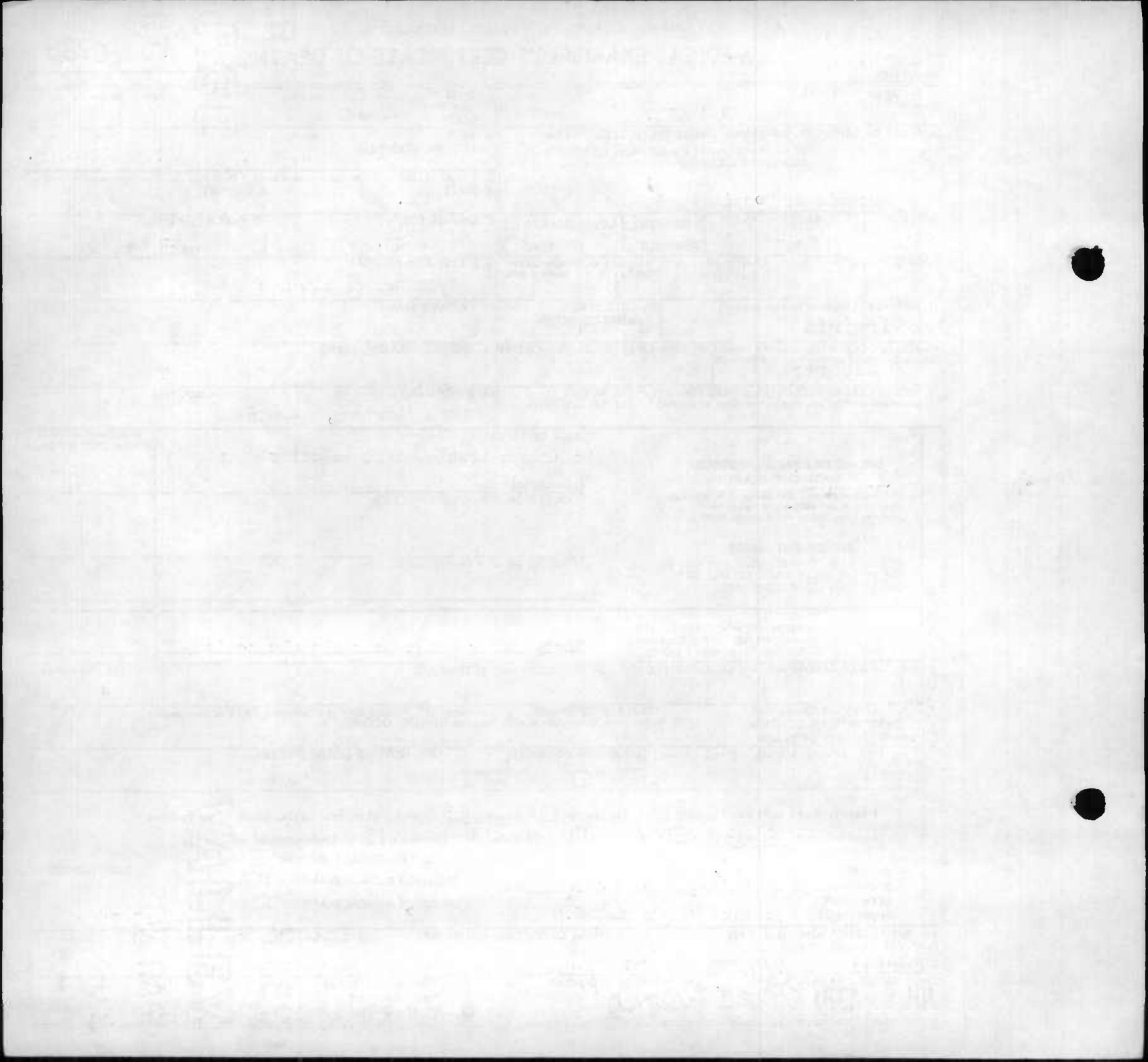


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

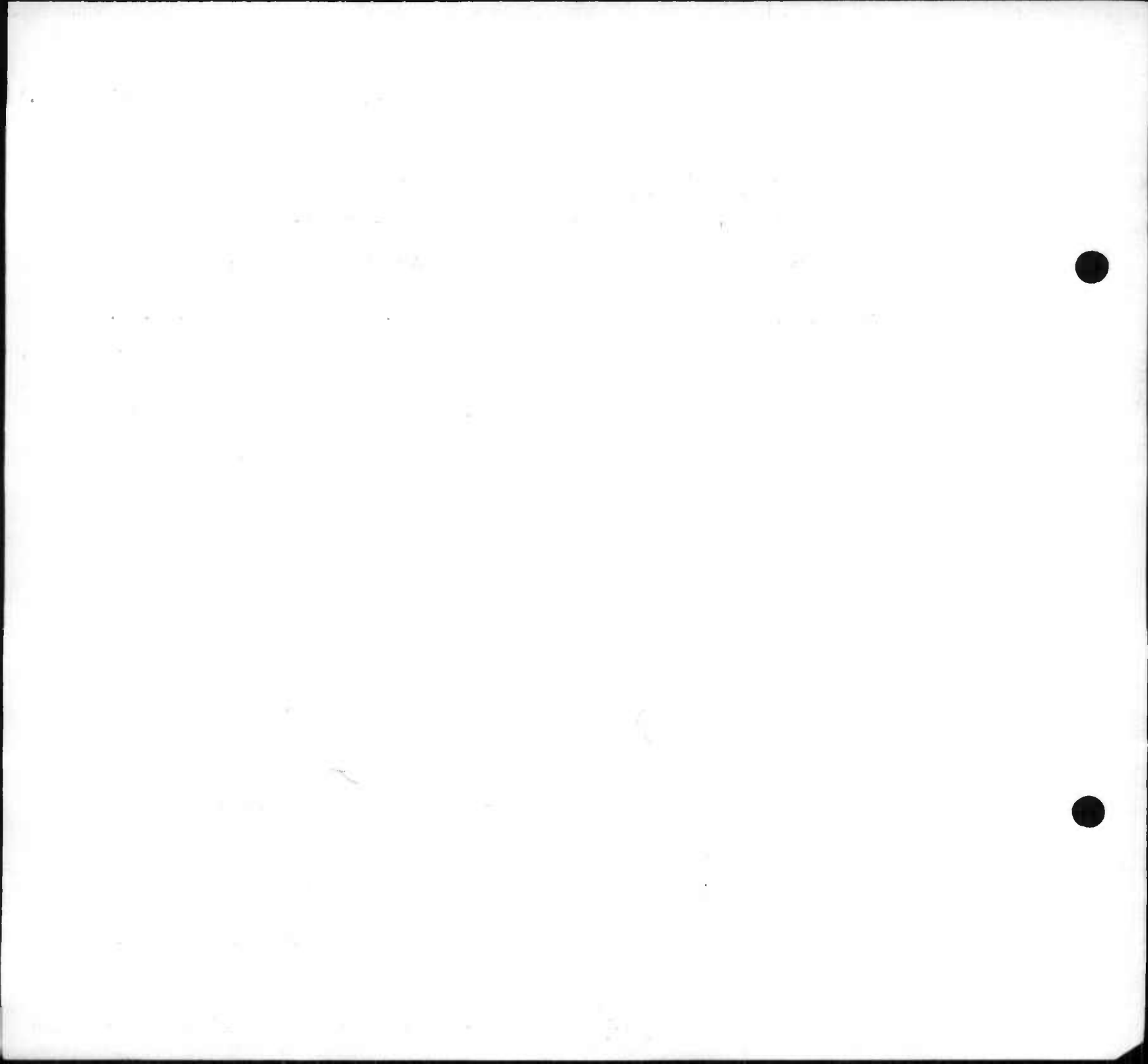
REG. NO.

1. NAME OF DECEASED (Type or Print) FLOYD CARTER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location) 39 Provident Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 6 30 1970 12:40 P.M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH				10. AGE (in years last birthday) 52		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME ?		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1402	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				16. KIND OF BUSINESS OR INDUSTRY ?			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				18. SOCIAL SECURITY NO.		19. INFORMANT Pearl Carter, Same	
20. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Fatty liver due to chronic alcoholism							
22A. DATE OF OPERATION				22B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22E. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 7-1-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/7/70			
24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore MD			
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970				25B. NAME OF REGISTRAR Robert E. J. [Signature]			
25C. FUNERAL DIRECTOR A Halstead				ADDRESS 1206 W north Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

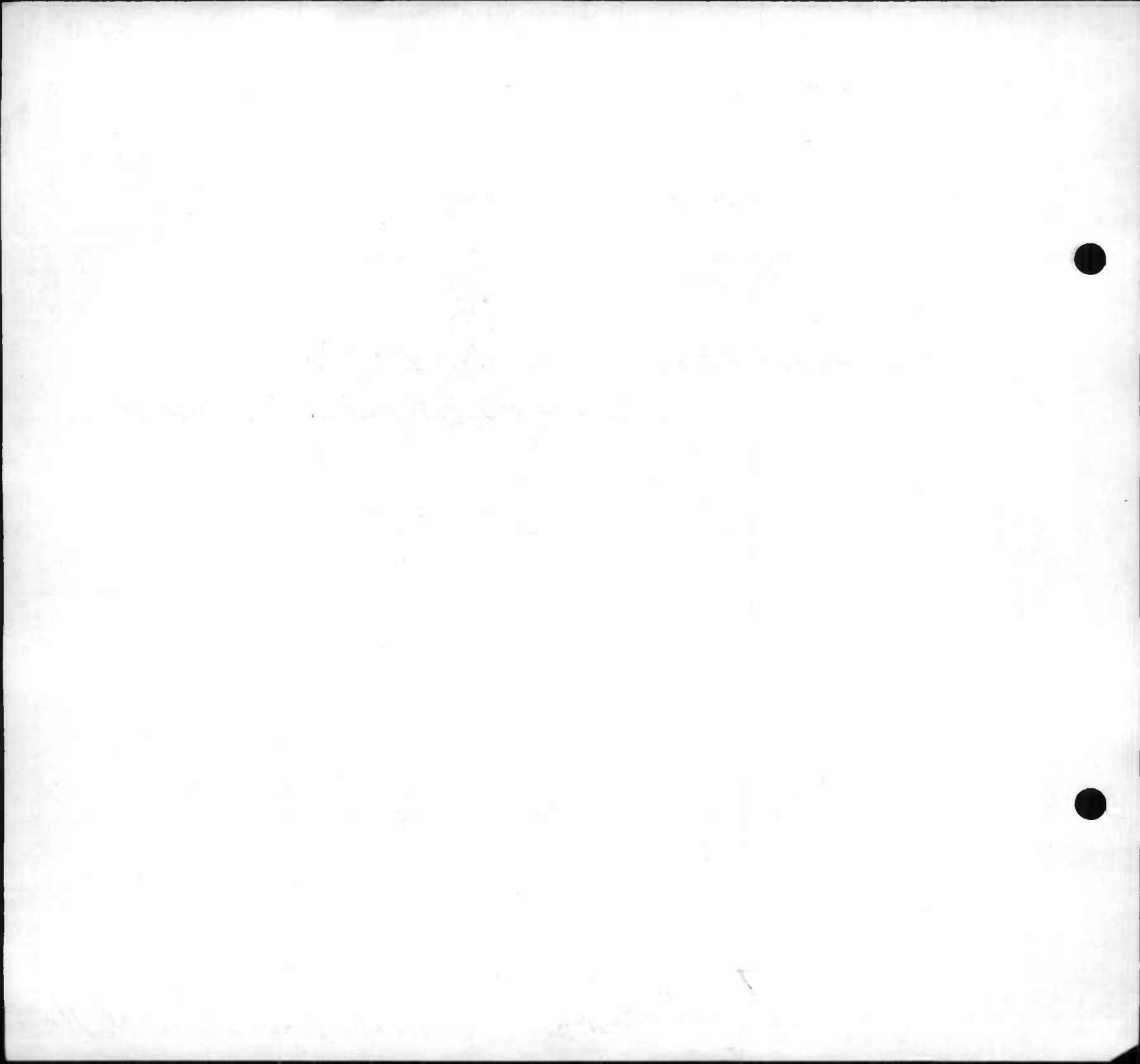
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>70 6739</u>	
W-426 70 6739			
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) <u>Walker, Marie</u>		2. DATE AND HOUR OF DEATH <u>7-1-70</u> <u>6:10</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>39 Provident Hospital</u> <u>1514 Divison Street</u> <u>Baltimore, Maryland 21217</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1702</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1220 McCulloh St.</u>	
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1917</u>
9. AGE (in years last birthday) <u>52</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MA Active D. S. S.</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Murry Walker-Husband</u>		ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ASHD & congestive HEART Failure & Thoracic Aortic Aneurysm</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-25-70</u> 19__ to <u>7-1-70</u> 19__ that (I) (we) last saw the deceased alive on <u>7-1-70</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Elijah Runder</u>		23B. DATE SIGNED <u>July 2, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>Elijah Runder</u>		23D. ADDRESS <u>1514 Divison Street Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/5/70</u>	24C. NAME of CEMETERY or CREMATORY <u>MT Auburn Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>	25C. FUNERAL DIRECTOR <u>Adolphus Walstead</u> ADDRESS <u>1206 W North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>70 6740</u>	
BIRTH NO. <u>70 6740</u>		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>William Lewis</u>		2. DATE AND HOUR OF DEATH <u>7/2/70</u> <u>12:00 A.M.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>M.D.</u> B. COUNTY <u>1703</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland General Hosp.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
5. SEX <u>M</u>		6. RACE <u>B</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>JUNE 3 1896</u>	
13. FATHER'S NAME <u>BENJAMIN LEWIS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA JONES</u>		9. AGE (in years last birthday) <u>74</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-12590</u>		17. INFORMANT <u>SANDRA JACKSON</u>	
18. <u>1621 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent Causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Bronchogenic CA</u> DUE TO (B) <u>CHF 2° A</u> DUE TO (C) <u>Renal Failure</u>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/21</u> 19 <u>70</u> to <u>7/2</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>7/2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael G. K.</u> M.D.				23B. DATE SIGNED <u>7/2/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>B. MANEJWALA</u> M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7-7-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTO NATIONAL</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO CITY</u> <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Kenneth Law Funeral Home</u>		25D. ADDRESS			



70 6741 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6741

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES B. COOKSEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour July 2, 1970 9:30 P.M.	
6. SEX Male		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE White		C. CITY OR TOWN St. Petersburg, 33702	
9. DATE OF BIRTH Aug 24 1910		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 59		E. STREET AND NUMBER 8431 5th Street North 33702	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Clerk		14B. KIND OF BUSINESS OR INDUSTRY Liquor Store	
15. MOTHER'S MAIDEN NAME Sally Watson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 212-01-1098		18. INFORMANT ADDRESS Mrs. Sylvia L. Cooksey (Wife) Same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic Cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/3/70 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE Sun July 5 70	
24C. NAME OF CEMETERY or CREMATORY Anderson-McQueen		24D. LOCATION (City, town, or county) (State) St. Petersburg, Florida	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Evans, M.D.	
25C. FUNERAL DIRECTOR Curtis E. Evans		ADDRESS 1400 S. Charles St Balto Md 21230	

ACADEMIC BOARD

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6742	
BIRTH NO. 70 6742		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) James L. Wilkins		2. DATE AND HOUR OF DEATH 6-30-70 8:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Maryland Baptist Aged Home		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balto.			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Maryland Baptist Aged Home		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2-8-1899		9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister	
11. BIRTHPLACE (State or foreign country) Bethel, N.C.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Henry Wilkins	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-45-4820	
17. INFORMANT Clarence Dixon		ADDRESS 4321 Fairfax Rd.		18. CAUSE OF DEATH Ca of lung	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II		20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Carol J. Johns, M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/2/70	
23C. PHYSICIAN'S NAME (Type) Carol J. Johns, M.D.		23D. ADDRESS The Johns Hopkins Hospital, Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-4-70		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery Anne Arundel Co., Md.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Randolph J. Collick			
ADDRESS 2431 E. Oliver St.					

NO Prev. Address

Admitted 11/29/65.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WALTER B. LOSIEWSKI

2. DATE AND HOUR OF DEATH

4 Jul 70

1 9 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4940 Eastern Avenue Baltimore, Maryland 21224

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE

B. COUNTY

Md -1

203

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1623 Shakespeare St 21231

5. SEX

Male

6. RACE

White

7. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

12-5-12

9. AGE (In years last birthday)

57

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HARBOR WORKER

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland U.S.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

STANLEY (Jr)

14. MOTHER'S MAIDEN NAME

Viola

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-10-1862

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH: Records Baltimore, Maryland 21224

18.

146.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Anaplastic Carcinoma

L Tonsil

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

26 mos

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

9 May 69

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

CA Tonsil

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (M) (this hospital) attended the deceased from 3 Feb 70 19 to 4 Jul 1970 that (M) (we) last saw the deceased alive on 4 Jul 70 19 and that (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (M) (did) (did not) view the body after death.

23A. SIGNATURE

Edmund Beacham M.D.

Attending Phys. ☐Med. Director ☒Staff Phys. ☐

23B. DATE SIGNED

4 Jul 70

23C. PHYSICIAN'S NAME (Type)

Edmund Beacham, M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-8-1970

24C. NAME of CEMETERY or CREMATORY

Holy Rosary

24D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 6 1970

25B. NAME OF REGISTRAR

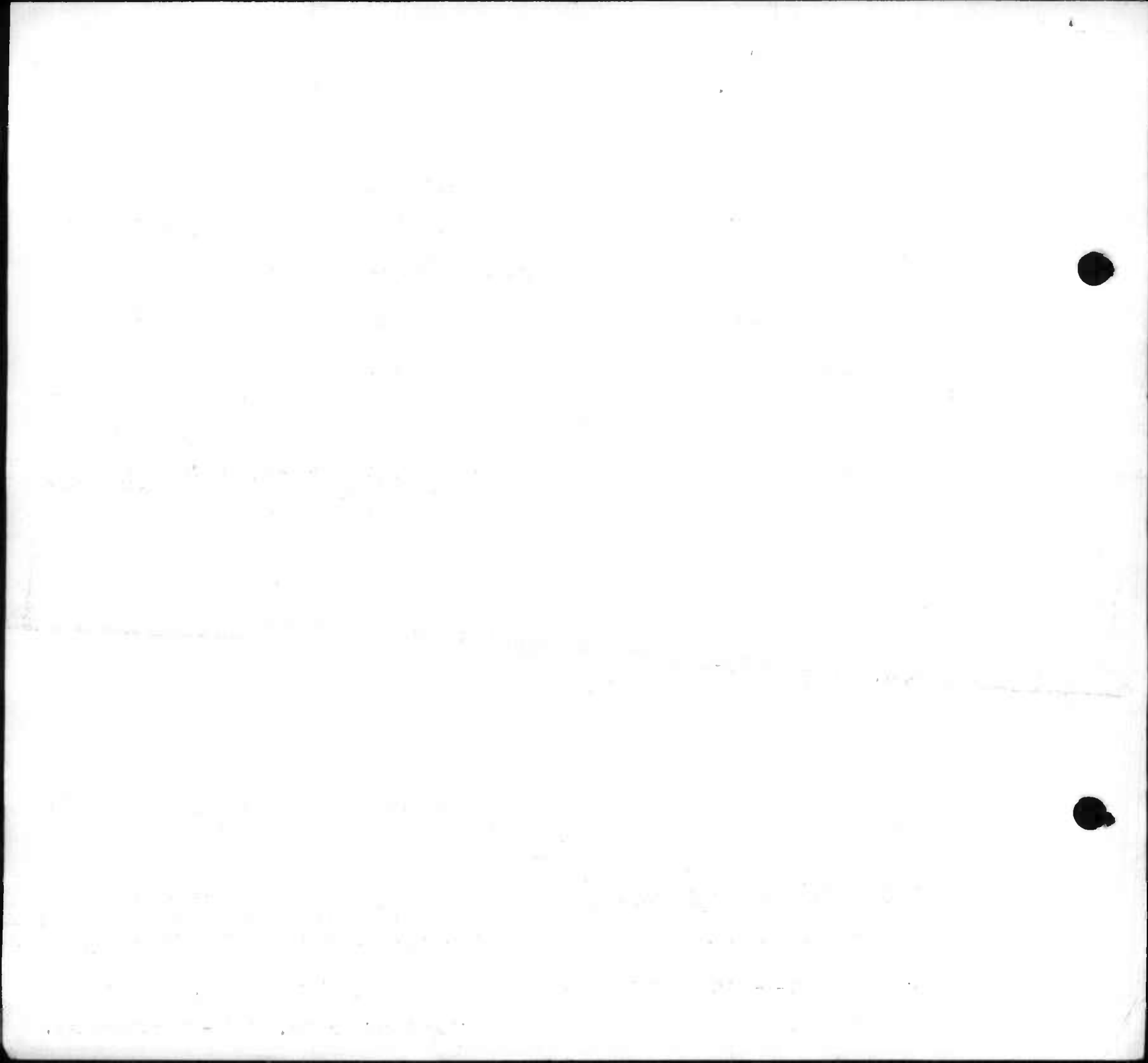
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Lilly & Zeller Inc.

ADDRESS

1901-07 Eastern Ave.



1

V-563

70

6744

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6744

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM VINYARD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 112 S. Mount Street		3. DATE PRONOUNCED DEAD Month Day Year Hour July 3, 1970 2:47 A. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1903			
6. SEX Male	7. RACE White	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 4/10/14	10. AGE (In years last birthday) 56	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
E. STREET AND NUMBER 112 S. Mount Street			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	
14B. KIND OF BUSINESS OR INDUSTRY -		15. MOTHER'S MAIDEN NAME unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Elizabeth Vinyard		ADDRESS 112 S. Mount St.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) NO			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/3/70 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/70	
24C. NAME OF CEMETERY or CREMATORY Louden Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR George L. Schwalbe, Inc.		ADDRESS	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WALTER JEFFRIES

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00

2735 Riggs Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

July 2, 1970

2:18 P.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

1606

6. SEX

Male

7. RACE

Colored

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Nov. 21, 1905

10. AGE (In years
last birthday) 64If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2735 Riggs Avenue

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thaddeus Jeffries

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Barber

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mellie Mills

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Augustine Jeffries 2735 Riggs Ave.

19. 4124

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/3/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-6-1970

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 6 1970

25B. NAME OF REGISTRAR

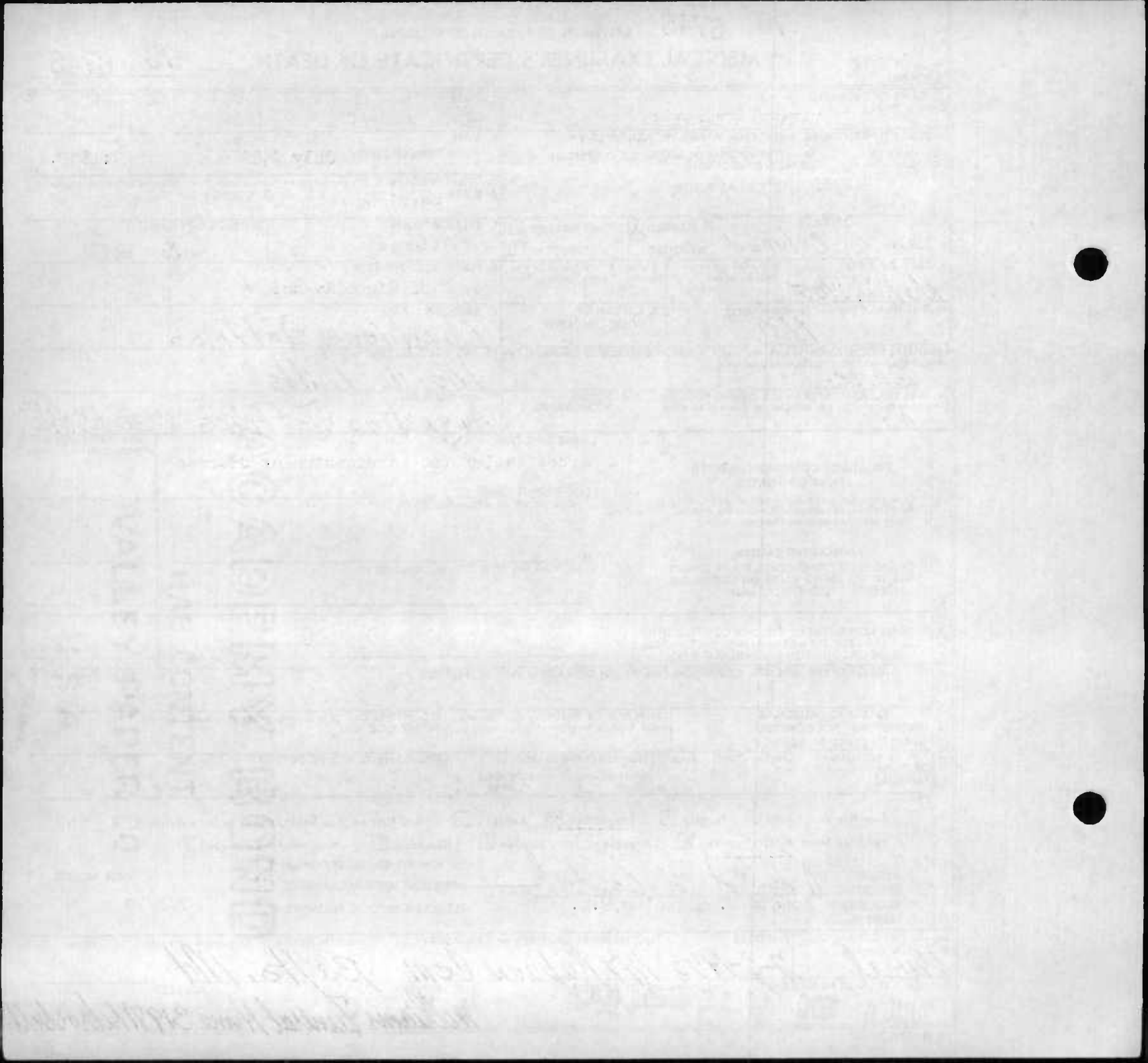
Robert L. Williams

25C. FUNERAL DIRECTOR

Williams Funeral Home

ADDRESS

319 N. Calhoun St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-500 70 6746		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6746	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Mary A. Ganey		2. DATE AND HOUR OF DEATH July 2, 1970 7 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 1401 B. COUNTY		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. STREET AND NUMBER 1421 John St.		5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-1876 9. AGE (in years last birthday) 93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10B. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown Smith		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-48-3310		17. INFORMANT C. Allen Hechter 6 Club Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease 18+ yrs		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 12/31/1952 to 7/2/1970 that (I) (we) last saw the deceased alive on 6/29/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. William F. Renner		23B. DATE SIGNED 7/2/70		23C. PHYSICIAN'S NAME (Type) Dr. William F. Renner	
23D. ADDRESS 3222 St. Paul St.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-4-70	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970	
25B. NAME OF REGISTRAR H. W. Jenkins		25C. FUNERAL DIRECTOR Sons Co. 4905 York Rd. Baltimore, Md. 21212		ADDRESS	

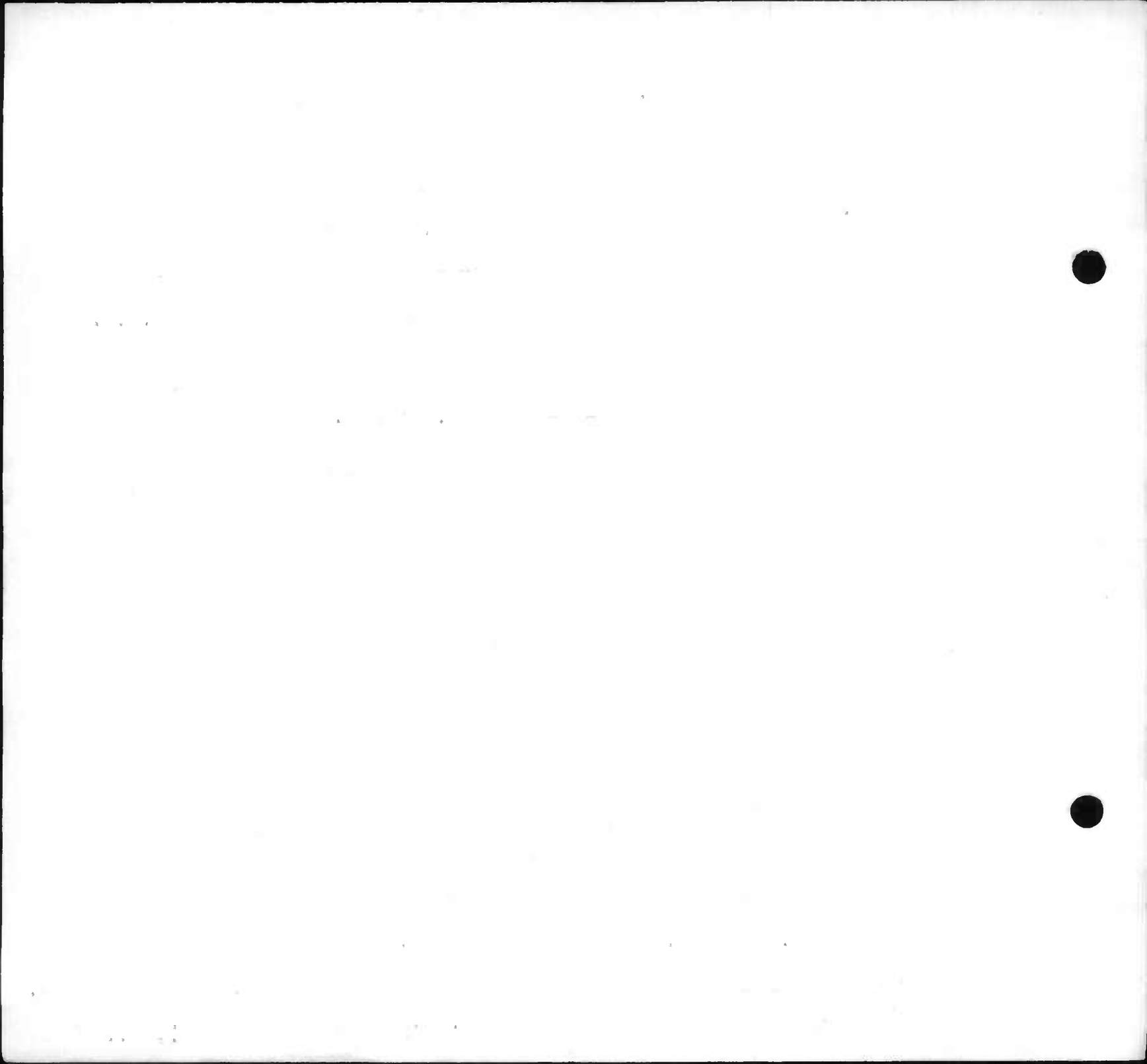
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-520		70 6747		BALTIMORE CITY HEALTH DEPARTMENT		70 6747	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Elizabeth M. Lyons				July 1, 1970 3:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
7 E. 27th Street				Maryland			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				7 E. 27th Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4-9-1891	79		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Own Home		Ireland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
O'Keefe				Mary			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				215-40-1669		Mr. John J. Lyons 200 Murdock Road	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				2 days			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				1 week			
ANTECEDENT CAUSES				2 years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				18 yrs. 23 yrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 1 19 52 to June 19 70 that (I) (we) last saw the deceased alive on June 24 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Dr. Harry F. Klinefelter				7/2/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr. Harry F. Klinefelter				550 N. Broadway			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7-4-70		New Cathedral Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 6 1970		Robert E. Jenkins, Jr.		H. W. Jenkins & Sons Co.		1905 York Road Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-120		70 6748		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6748	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) James Stephen Davis			
2. DATE AND HOUR OF DEATH July 2, 1970 11:30 P. M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 90 Harford Gardens Nursing Home			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 1201				5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harford Gardens Nursing Home			
6. CITY OR TOWN Baltimore		7. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8. STREET AND NUMBER 225 Wendover Rd.			
9. SEX M	10. RACE W	11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	12. DATE OF BIRTH 4-23-1899	13. AGE (In years last birthday) 71	14. If Under 1 Yr. Months: Days: Hours: Min.	15. If Under 24 Hrs. Min.	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		17. KIND OF BUSINESS OR INDUSTRY Columbia Specialty Co.		18. BIRTHPLACE (State or foreign country) Baltimore, Md.		19. CITIZEN OF WHAT COUNTRY? USA	
20. FATHER'S NAME James Davis		21. MOTHER'S MAIDEN NAME Annie C. G. Murphy		22. INFORMANT Genevieve A. Davis		23. ADDRESS Same	
24. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		25. SOCIAL SECURITY NO. 215-07-0096		26. MEDICAL CERTIFICATION		27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
28. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteriosclerotic Cardiovascular Disease		29. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		30. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		31. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Carcinoma of Neck	
32. DATE OF OPERATION 0		33. CONDITION FOR WHICH OPERATION WAS PERFORMED		34. AUTOPSY? (Yes or No) no		35. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
36. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		37. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		38. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		39. HOW DID INJURY OCCUR?	
40. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		41. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		42. I certify that (I) (this hospital) attended the deceased from June 19 68 to July 19 70 that (I) (we) last saw the deceased alive on July 1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		43. SIGNATURE Dr. Loy M. Zimmerman	
44. PHYSICIAN'S NAME (Type) Dr. Loy M. Zimmerman		45. ADDRESS 3202 Harford Road		46. DATE SIGNED 7/3/70		47. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
48. BURIAL CREMATION REMOVAL (Specify) Burial		49. DATE 7-6-70		50. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		51. LOCATION (City, town, or county) (State) Baltimore, Md.	
52. DATE REC'D BY HEALTH DEPT. JUL 6 1970		53. NAME OF REGISTRAR Robert E. Taber, M.D.		54. FUNERAL DIRECTOR H. W. Jenkins Sons Co.		55. ADDRESS 4905 York Rd. Baltimore, Md. 21212	

7-150

70 8148

70 8148

1:30 p.

70 8148

70 8148

Arteriosclerotic Cardiovascular Disease

hyper

70 8148

Carcinoma of Neck

3 year

70

1/17

88 -

June 20

1/17

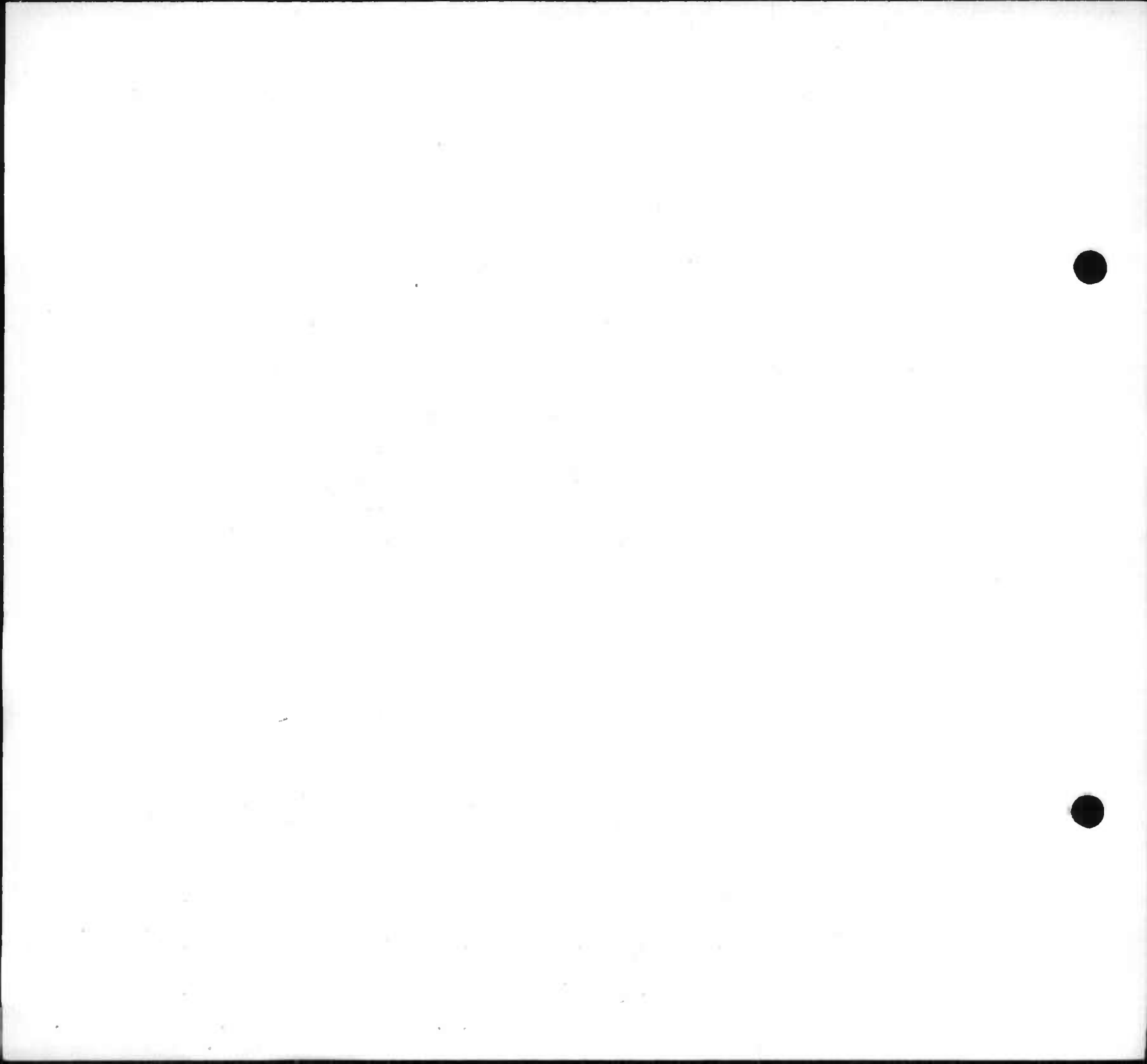
2/3/20

for M. J. [Signature]

FUNERAL DIRECTOR: IMPORTANT

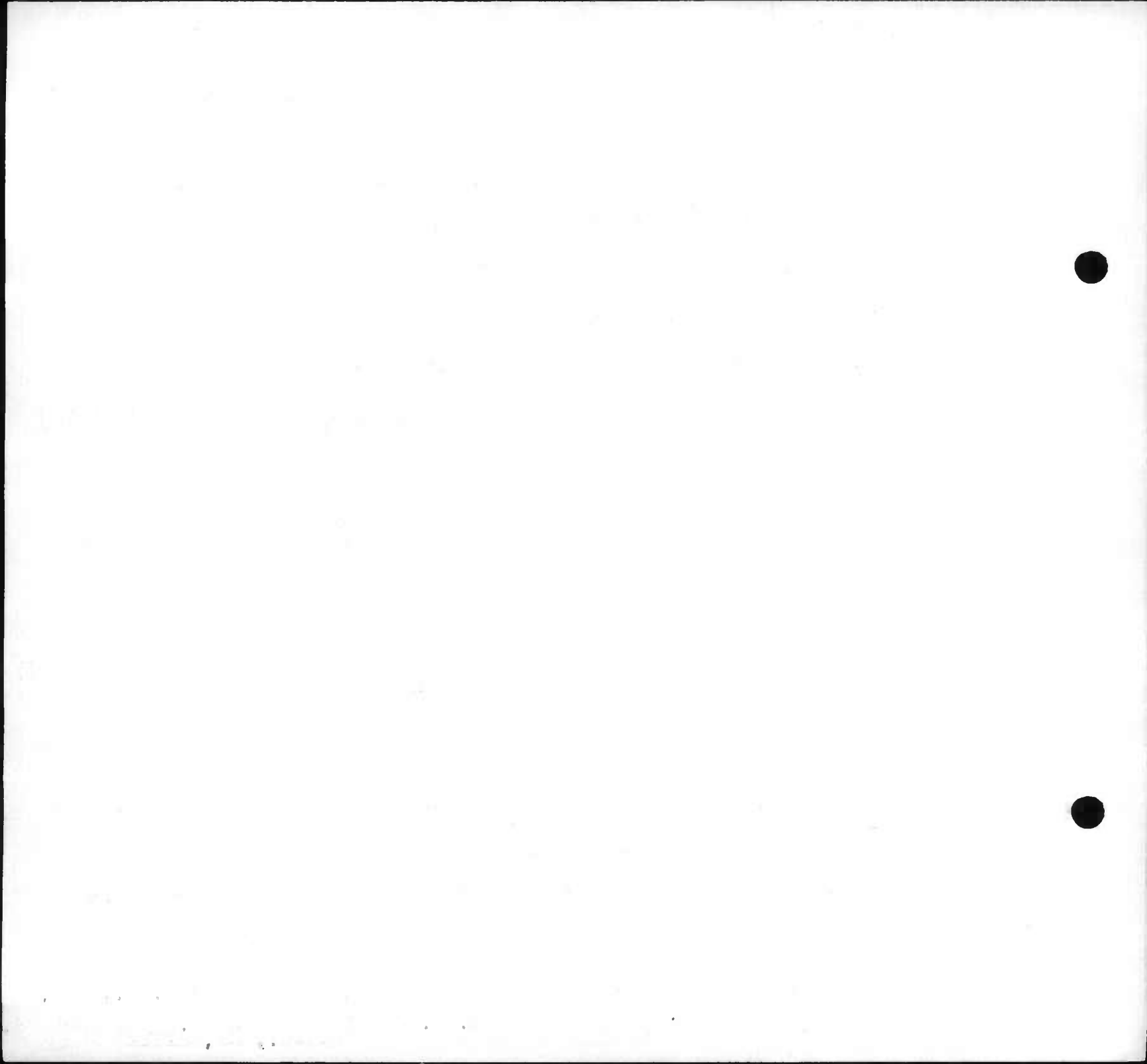
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
B-240 70 6749		CERTIFICATE OF DEATH		70 6749	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Dorothy Bokel			July 5, 1970 12:10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 431 Notre Dame Lane			Md. 2711		
5. SEX			6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
F			W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
Retired			Recorder-Peabody		3-30-1893
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)
J. Antone Bokel			Helen Gallagher		77
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)
no			220-44-7123		Baltimore, Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			Martha Bokel		USA
ANTECEDENT CAUSES			Same		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
			acute heart failure		
			arteriosclerotic degenerative		
			C.V. Disease, Hypertension		
			Cerebral Vascular Insufficiency		
			DUE TO, OR AS A CONSEQUENCE OF:		
			(c)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 30 Oct. 1962 to 5 July 1970 that (I) (we) last saw the deceased alive on 5 July 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph E. Muse, Jr. M.D.				6 July '70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Joseph E. Muse, Jr. M.D.				Wilkins & Pine Hgts. Ave. St. Agnes Medical Center 6210 Mossway	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-9-70		St. Mary's Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 6 1970		Robert E. Fisher, Jr.		U.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-625 70 6750		BALTIMORE CITY HEALTH DEPARTMENT		70 6750	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>JAMES G. MORGAN, SR.</u>			2. DATE AND HOUR OF DEATH <u>July 2 1970</u> <u>9 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 EDGEWOOD NURSING HOME</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1201</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>103 W. 39th ST</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-08</u>	9. AGE (in years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEXTON - SHARE OF SACRED HEART CHURCH</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HARRY G. MORGAN</u>			14. MOTHER'S MAIDEN NAME <u>NELLIE C. WHITE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219-07-1790</u>		17. INFORMANT <u>MRS. FANNY MORGAN (SAME)</u>
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>seconds</u> <u>2+ years</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 4 1970</u> to <u>July 2 1970</u> that (I) (we) last saw the deceased alive on <u>July 1 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frederick J. Vollmer MD</u>			23B. DATE SIGNED <u>July 2, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7/6/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR <u>B. W. Jenkins & Sons Co.</u>		
25D. ADDRESS <u>4905 York Rd. Balto., Md. 21212</u>					



FUNERAL DIRECTOR: IMPORTANT

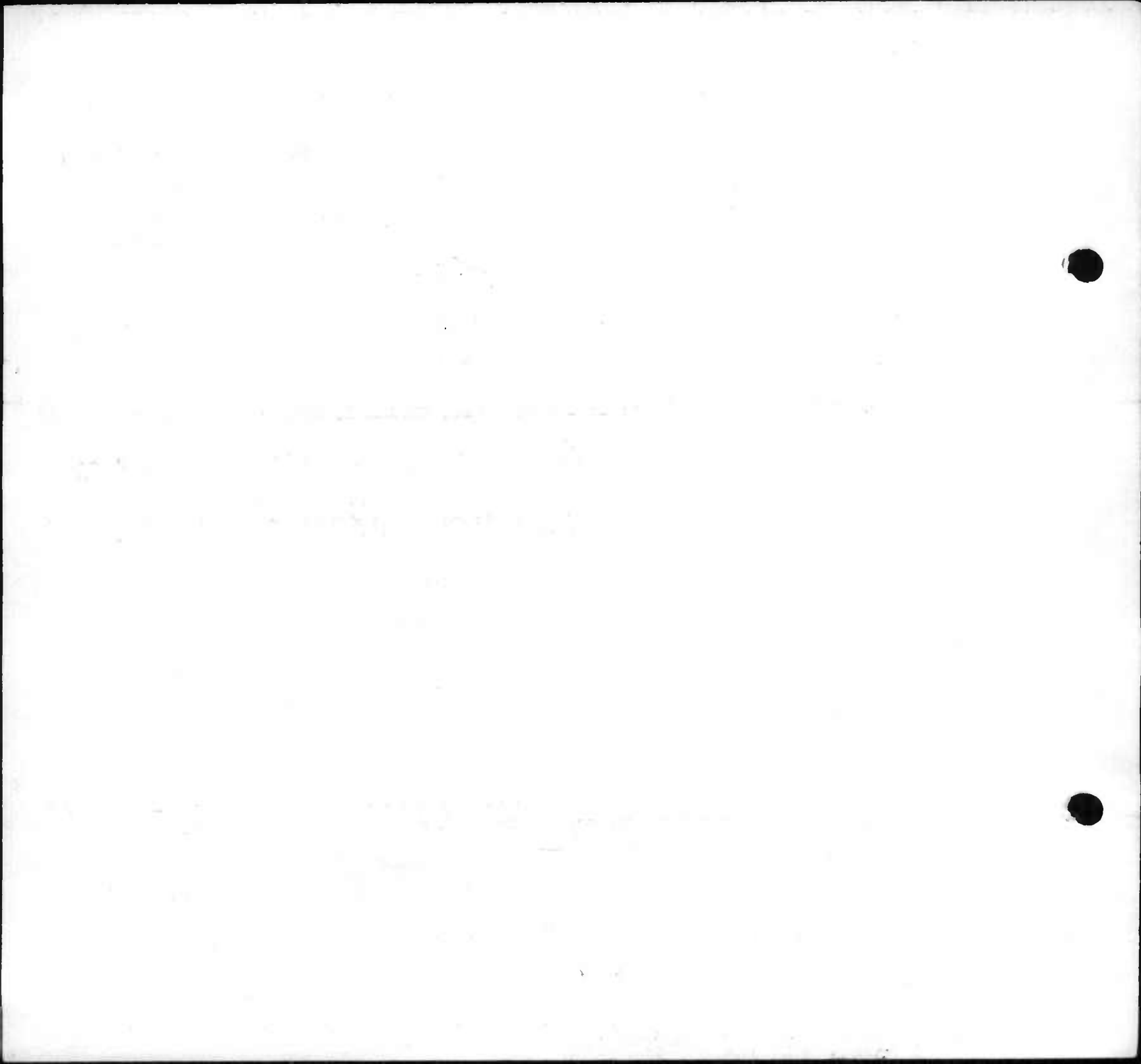
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-235 70 6751		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X 70 6751	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		OXMAN, MARY		7-2-70 6:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND 31110		5300	
KING HOSPITAL OF BALTIMORE, MD.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		3105 TENEN RD, 21215			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (At years last birthday)	10. UNDER 1 Yr. Months: Days
F	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6-15-98	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Russia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
M		Bella		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				MAY OPMAN	
				ADDRESS	
				Same	
18. 410.7 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		MYOCARDIAL INFARCTION	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(B) DUE TO, OR AS A CONSEQUENCE OF:		ACVD	
ANTECEDENT CAUSES		(C) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 7-1-70 to 7-2-70 that (we) last saw the deceased alive on 7-2-70 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
R. Balazar, MD		7-2-70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
RO MUJO F. BALTAZAR, M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		7/3/70		Shearon T. Feltch	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 6 1970		Robert E. Taylor, Jr.		Sylvan Lewis 2501 9610 Reisterstown Rd	

TANFY Rd.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6752</u>	
BIRTH NO. <u>C-455</u>		70 6752			
1. NAME OF DECEASED (Type or Print) <u>Leonard S. Coleman</u>			2. DATE AND HOUR OF DEATH <u>July 2, 1970</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3806 W. Garrison Avenue</u>			A. STATE <u>Maryland</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3806 W. Garrison Avenue 21215</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1889</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Tr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Western Md. Dairy</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Samuel Coleman</u>			14. MOTHER'S MAIDEN NAME <u>Laura Massey</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-8460A</u>	17. INFORMANT ADDRESS <u>Mrs. Thelma B. Coleman 3806 W. Garrison AV</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>None</u> (C) <u>None</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>6/29/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/29/1965</u> 19 <u>65</u> to <u>July 3</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>July 2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel Levin</u>			23B. DATE SIGNED <u>7/3/70</u>		
23C. PHYSICIAN'S NAME (Type) <u>Manuel Levine</u>			23D. ADDRESS <u>6101 Park Heights Avenue 21215</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 7, 1970</u>		24C. NAME of CEMETERY or CREMATORY <u>Baptist Church Cemetery Rhoadesville, Orange Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Loring Byers 8728 Liberty Road 21133</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CARLYLE EARP		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour July 2, 1970 7:24 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour July 2, 1970 7:24 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard	
9. DATE OF BIRTH 1-25-1891		10. AGE (in years lost birthday) 79	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY Riggs, Warfield Roloson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I & W W I I		17. SOCIAL SECURITY NO. 218-32-2750	
15. MOTHER'S MAIDEN NAME Mary V. Laynor		18. INFORMANT ADDRESS 21227 Mrs. Elizabeth Vaughan Earp, 5709 Main Street	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 28147		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 6-21-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22D. TIME OF INJURY (APPROX.) 6-21-70 9:18 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? U.S.#1 and Levering Street		22F. HOW DID INJURY OCCUR? Pedestrian struck by auto	
21. AUTOPSY? (Yes or No) No		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-1970	
24C. NAME OF CEMETERY or CREMATORY Silver Lake Cemetery		24D. LOCATION (City, town, or county) (State) Dover, Delaware	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and a statement of the results achieved. It is a general statement of the work done and is not a detailed report of the work of each department.

2. The second part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

3. The third part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

4. The fourth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

5. The fifth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

6. The sixth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

7. The seventh part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

8. The eighth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

9. The ninth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

10. The tenth part of the report deals with the work of the various departments. It is a detailed report of the work of each department and is a statement of the results achieved. It is a detailed report of the work of each department and is a statement of the results achieved.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

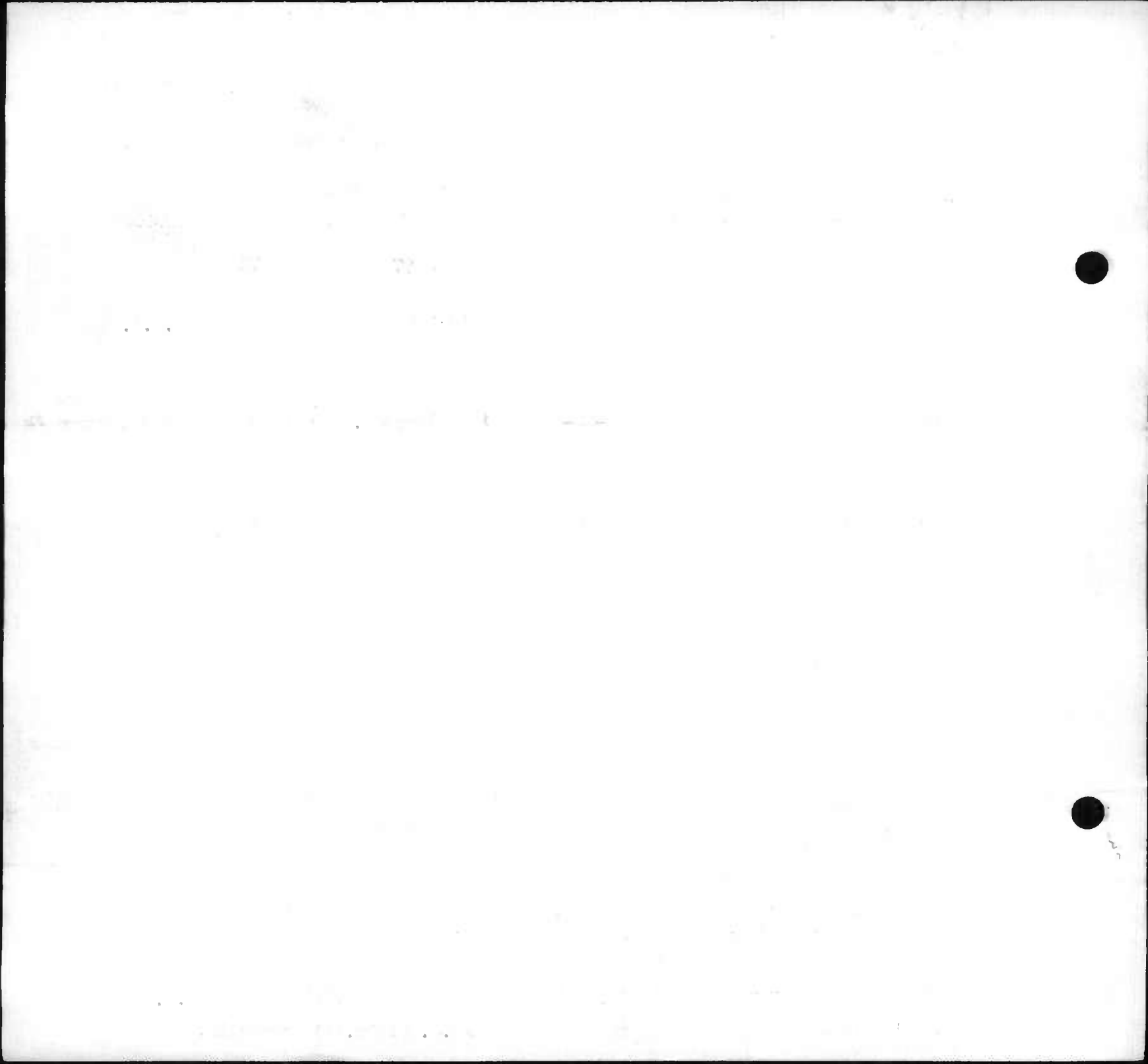
L-000 70 6754 BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. _____ REG. NO. 70 6754

1. NAME OF DECEASED (Type or Print) LEE, SCHEUFELE, GERTRUDE AMELIA		2. DATE AND HOUR OF DEATH JULY 2, 1970 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY 5300	
		C. CITY OR TOWN Highlands D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 2916 ILLINOIS AVENUE	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 03 04 26
9. AGE (in years last birthday) 44		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE OPERATOR C & P	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME CHARLES HITTEL		14. MOTHER'S MAIDEN NAME GERTRUDE (WALTERS)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216 20 3659	
		17. INFORMANT Mr. Joseph W. Lee, 2916 Illinois Ave. 21227 ST AGNES HOSP RECORDS-BALTO MD 21229	
18. 56717 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF: SEPTIC SHOCK (B) GENERALIZED PERITONITIS DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JUNE 16 19 70 to JULY 2 19 70 that (IX) (we) last saw the deceased alive on JULY 2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Pricha Boonswang, M.D.		23B. DATE SIGNED 07 02 70	
23C. PHYSICIAN'S NAME (Type) PRICHA BOONSWANG M.D.		23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-4-1970	24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery	24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Hubbard	25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21227

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

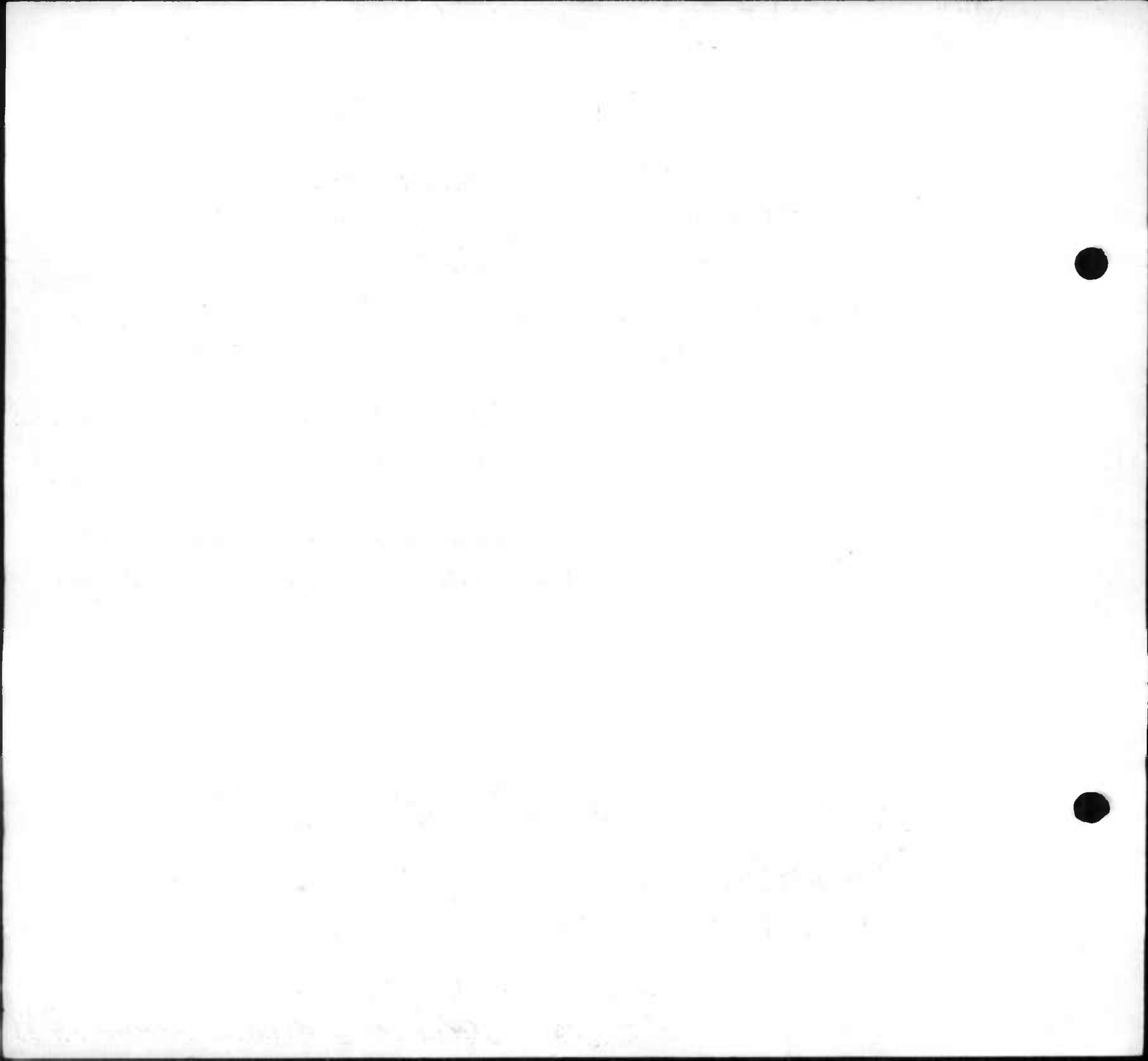
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

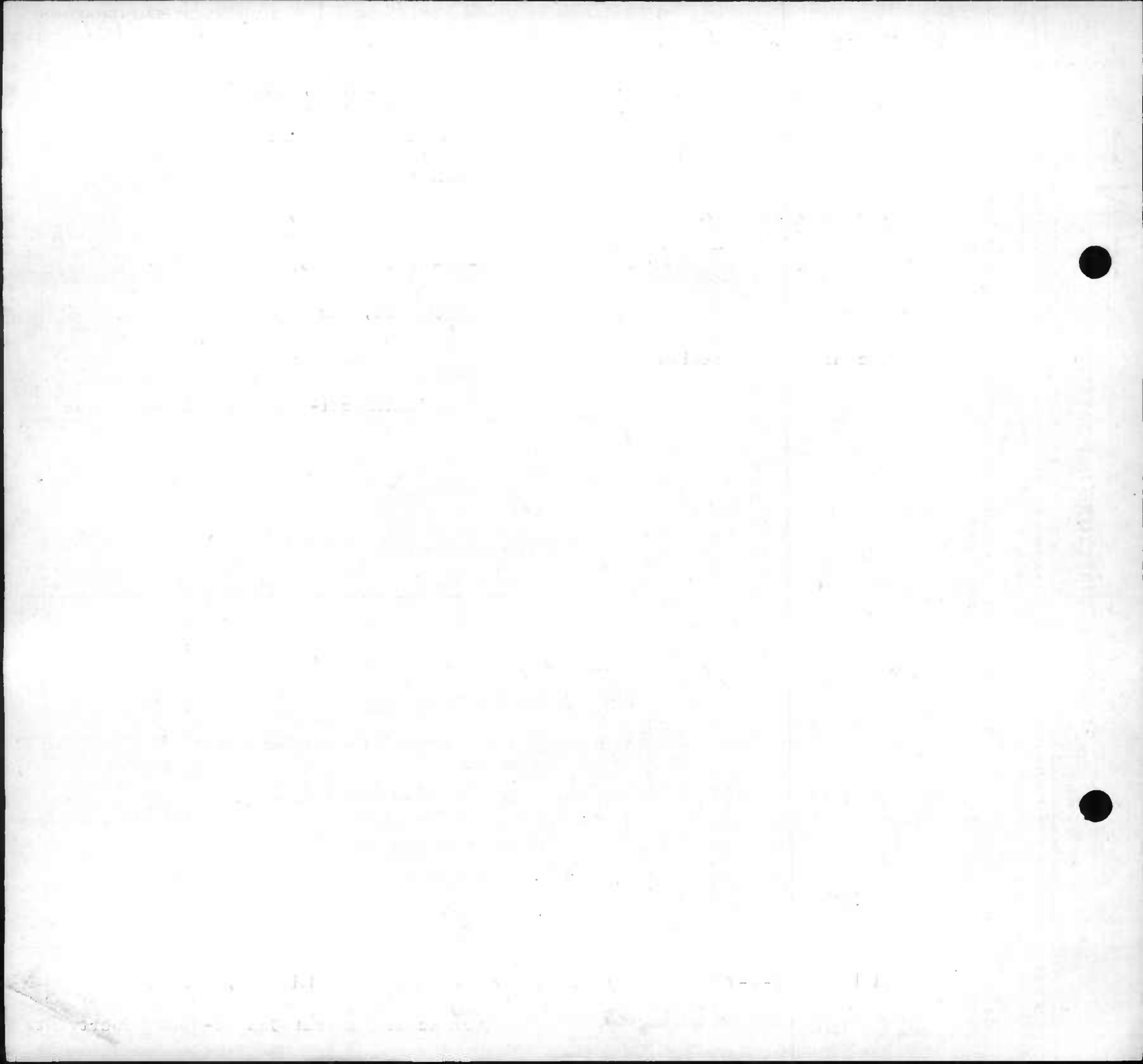
K-500 70 6756		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 6756	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DAVID A. KOEHNE		2. DATE AND HOUR OF DEATH 6/29/70 10¹⁹ P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSP BALTIMORE, MD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY AA		5200	
C. CITY OR TOWN SEVERNA PARK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 285 OAK COURT	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/61	9. AGE (In years last birthday) 8	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10B. KIND OF BUSINESS OR INDUSTRY and grade		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ANTHONY KOEHNE		14. MOTHER'S MAIDEN NAME Ellen Raftery	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Anthony J. Koehne - above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ASPIRATION (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PHARYNGEAL INCOMPETENCE (B) DUE TO, OR AS A CONSEQUENCE OF: PONTINE GLIOMA (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 mins 6 mos 2 1/2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indicate medical condition)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from JUNE 21 1970 to JUNE 29 1970 that (we) last saw the deceased alive on JUNE 29 1970 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE Joseph T. Coyle Jr MD		23B. DATE SIGNED 6/29/70		23C. PHYSICIAN'S NAME JOSEPH T COYLE JR MD	
23D. ADDRESS The Johns Hopkins Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7-2-70		24C. NAME OF CEMETERY or CREMATORY Beth Nat'l		24D. LOCATION (City, town, or county) (State) Beth Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Robert S. Lawrence	
25D. ADDRESS Severna Park					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

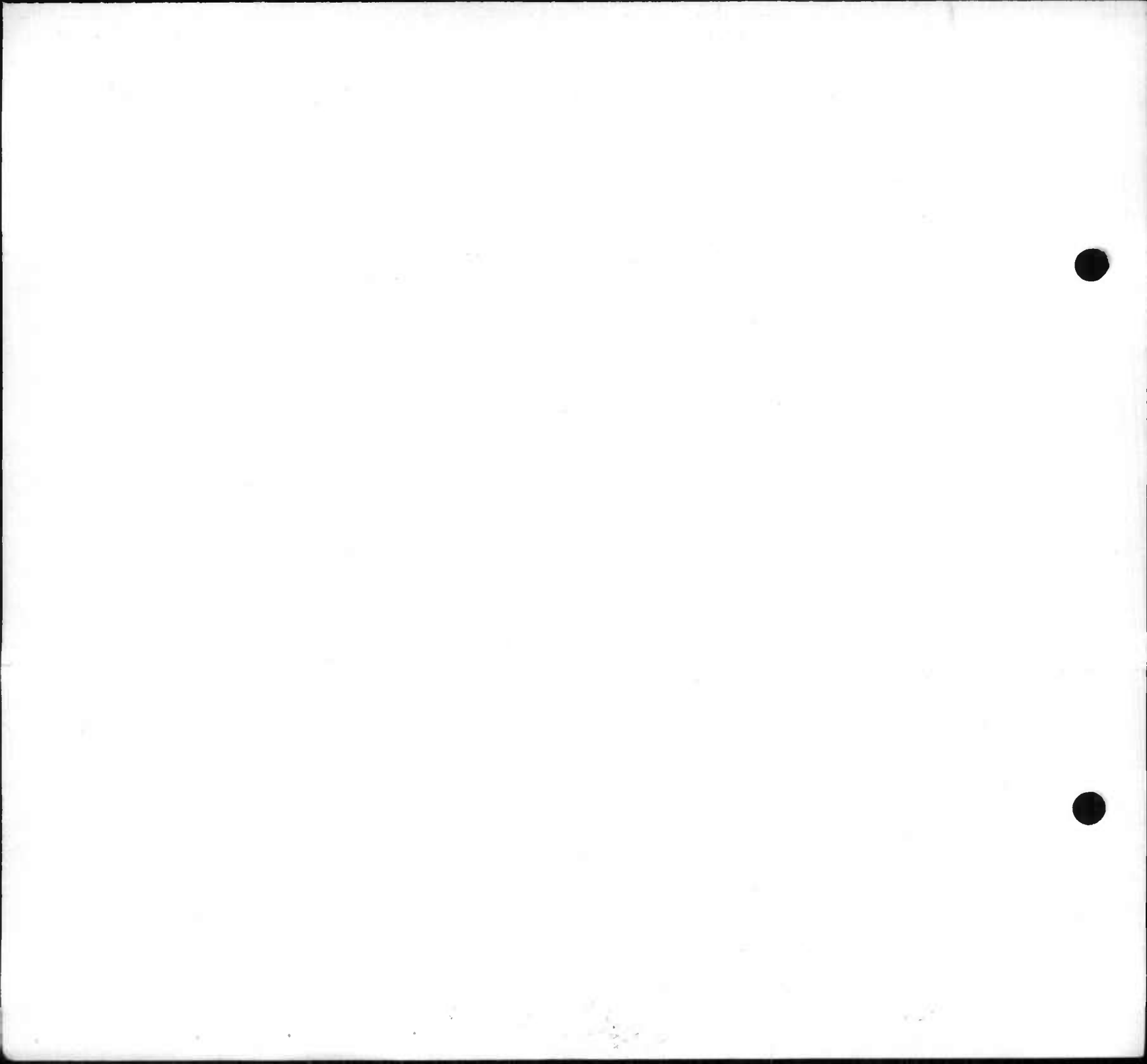
BIRTH NO. <u>G-625 70 6757</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 6757</u>	
1. NAME OF DECEASED (Type or Print) <u>Marie Graziano</u>				2. DATE AND HOUR OF DEATH <u>July 1, 1970</u> <u>7:45</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4418 Groveland Avenue</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4418 Groveland Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-20-1901</u>	9. AGE (In years last birthday) <u>69</u>	11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Vincent Graziano</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT ADDRESS <u>Lena Quattrochi-4418 Groveland Avenue</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>Prostatic Carcinoma Glands</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma of Prostate Glands 15 years</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>November 1966</u> to <u>July 1, 1970</u> , that (I) (we) last saw the deceased alive on <u>July 1, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Cecil Rudner MD</u>				23B. DATE SIGNED <u>7-2-70</u>		23C. PHYSICIAN'S NAME (Type) <u>CECIL RUDNER MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>7-6-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Jackson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Armocost Funeral Chapel-4600 Liberty Hts</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

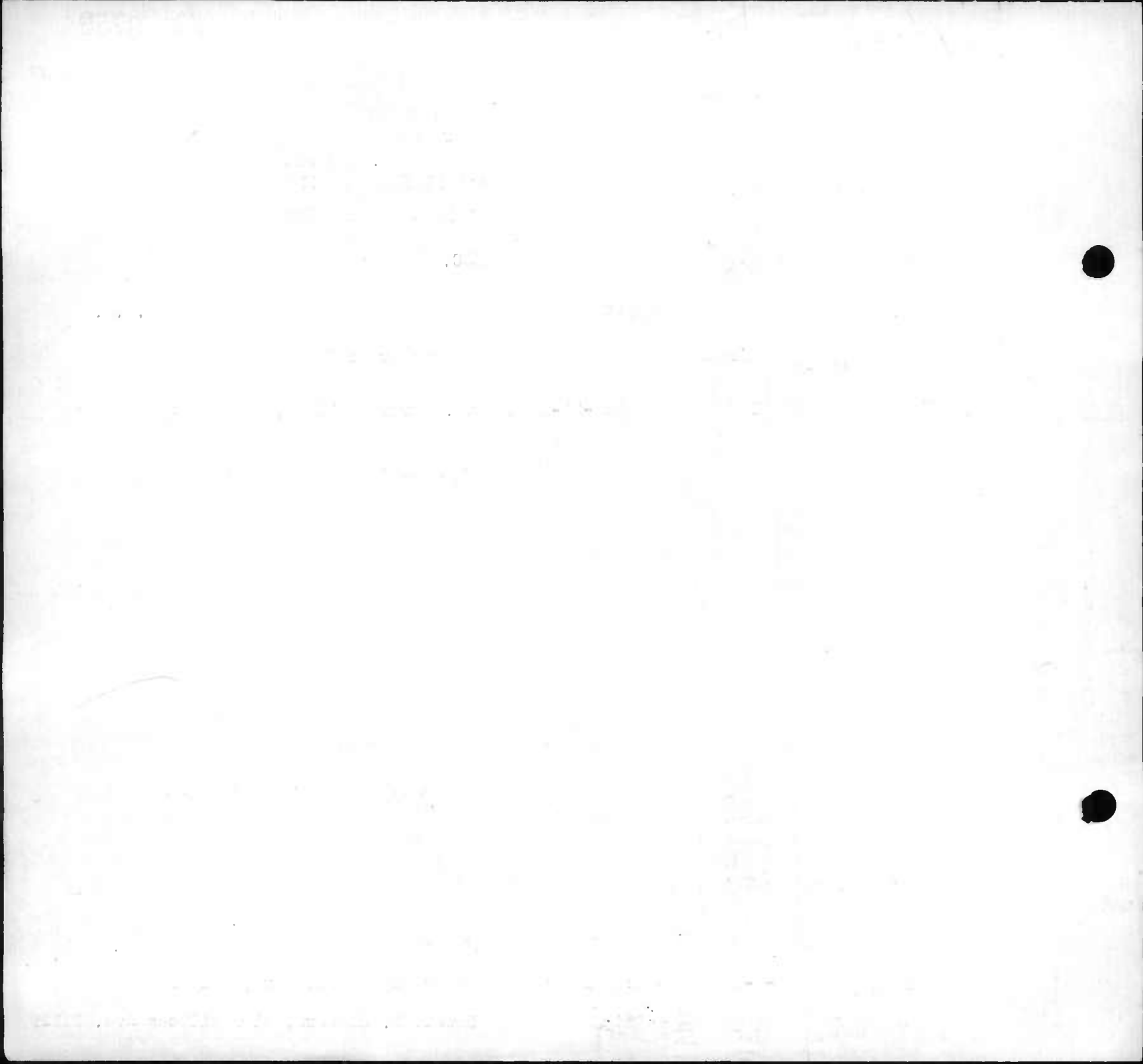
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6758</u>	
1. NAME OF DECEASED (Type or Print) <u>Ellen (Neddie) Byrnes</u>		2. DATE AND HOUR OF DEATH <u>7/2/70</u> <u>18:05 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Montebello State Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN <u>Balto</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>34 N. Linwood Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/23/05</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>James Bavis</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-28-8770</u>		17. INFORMANT ADDRESS <u>Hospital chart</u>	
18. <u>225-41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulm Embolus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
		(B) <u>Spinal cord meningioma</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>3 mo</u>	
		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>C.V.A.</u>					
19A. DATE OF OPERATION <u>6/12/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Spinal meningioma</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5/2/7</u> <u>19 70</u> to <u>7/2</u> <u>19 70</u> that <u>we</u> last saw the deceased alive on <u>7/2</u> <u>19 70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>F. Stuart, M.D.</u>		23B. DATE SIGNED <u>7/2/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Franklin Stuart</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/6/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Faber, Jr.</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Baltimore St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

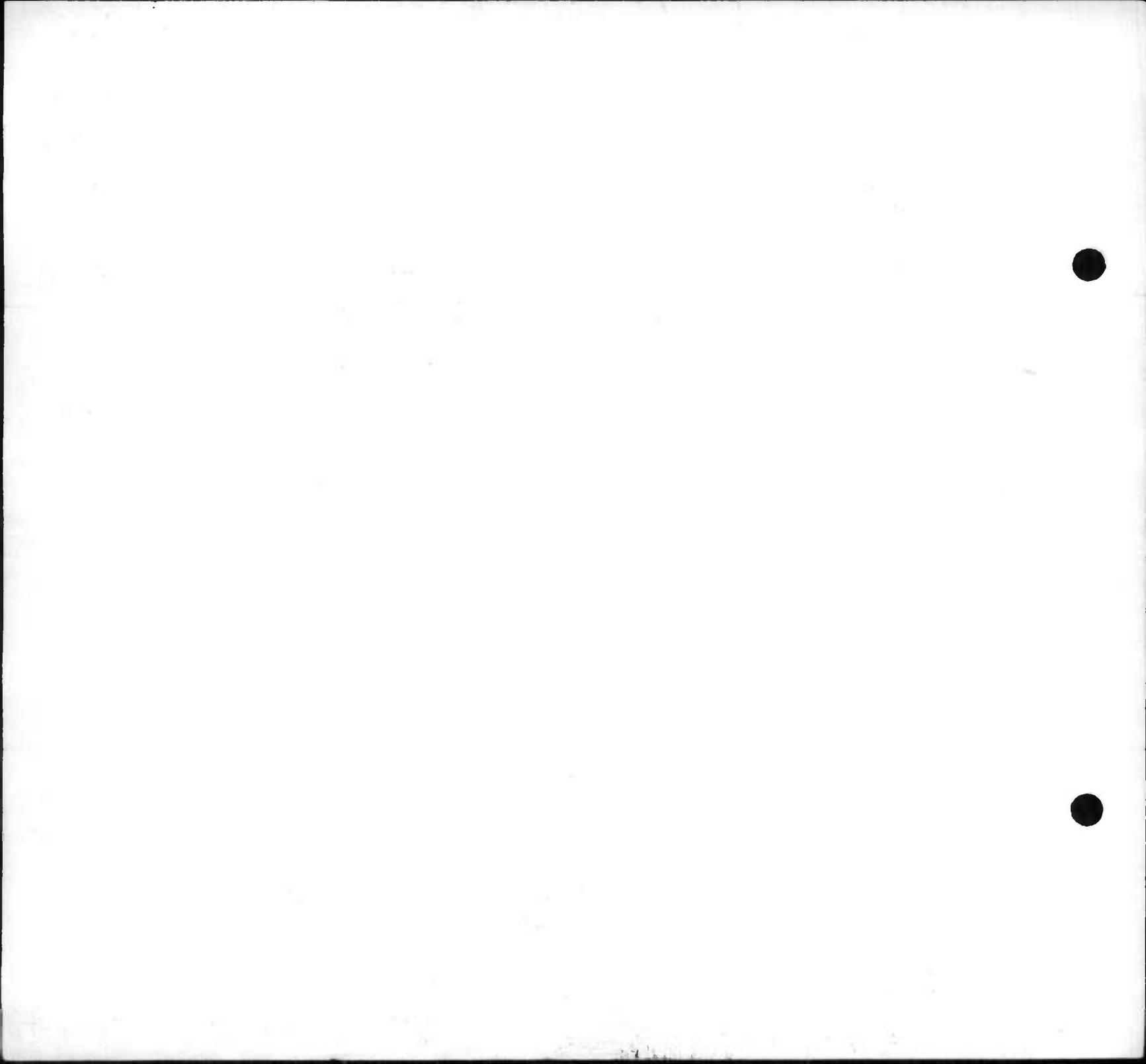
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6759
N-400		70 6759		CERTIFICATE OF DEATH
1. NAME OF DECEASED (Type or Print) Edward E Neale		2. DATE AND HOUR OF DEATH 7-2-70 10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED-DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Weller Street D.H.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2533 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2339 Annapolis Road		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 23-1890	9. AGE (In years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Neale		
14. MOTHER'S MAIDEN NAME Catherine Imhuff		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I		
16. SOCIAL SECURITY NO. 212-22-9781		17. INFORMANT Mrs. Gertrude Ellis, 2339 Annapolis Road		
18. 4123 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Myocardial infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 2-20 19 70 to 7-2- 19 70 , that (I) (we) last saw the deceased alive on 6-6- 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Vicente M. Ruelas M.D.		23B. DATE SIGNED 7-2-70		23C. PHYSICIAN'S NAME (Type) VICENTE M. RUELAS M.D.
23D. ADDRESS Spring Knx Sta. Hop. Cal. Catm...		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 7-6-1970		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6760 4</u>
BIRTH NO. <u>X-63470-11147</u>		6760		
1. NAME OF DECEASED (Type or Print) <u>KARDULIS Baby Girl</u>		2. DATE AND HOUR OF DEATH <u>7-1-70</u> <u>10:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Baltimore General Hospital South</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN <u>Glen Burnie</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>509 Stanhome Dr.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-70</u>	9. AGE (In years last birthday) <u>0 31</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>PAUL E. JR.</u>		
14. MOTHER'S MAIDEN NAME <u>Brenda DAVIS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u>		
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>D. D. Secreto RN Hosp.</u> ADDRESS <u>-</u>		
18. <u>756.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Multiple Congenital Anomalies</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Multiple Congenital Anomalies</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>7-1-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>no</u>		20A. AUTOPSY? (Yes or No) <u>no</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <u>7-1-70</u> 19 <u>70</u> to <u>7-1-70</u> 19 <u>70</u> that (I) (we) lost saw the deceased alive on <u>7-1</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Grace P. Hyman MD</u>		23B. DATE SIGNED <u>7-1-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Grace P. Hyman MD</u>
23D. ADDRESS <u>St. Baltimore Gen. Hosp.</u>		23E. DATE <u>7-1-70</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/13/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Redeemer Cem. Baltimore, Md.</u>
24D. LOCATION (City, town, or county) <u>Md.</u>		24E. TOTAL <u>1</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 6 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>John J. Cavanaugh Inc.</u> ADDRESS <u>9 Hollins St. S. Md.</u>



M-532 70 6761 BALTIMORE CITY HEALTH DEPARTMENT X
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 6761

BIRTH NO.		1. NAME OF DECEASED (Type or Print) John N Manthos		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 29 70 3:00 p. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia B. COUNTY V-43	
6. SEX male	7. RACE white	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Alexandria	
9. DATE OF BIRTH 2.20.1918		10. AGE (In years last birthday) 52		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U S A		E. STREET AND NUMBER 4080 Duke St.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		14B. KIND OF BUSINESS OR INDUSTRY Construction		15. MOTHER'S MAIDEN NAME Antonia Logotheti	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1939 to 1945		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Elen E. Manthos. same as #5e	
19. 412.41		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6/30/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7.2.1970		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Suitland. Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 6 1970		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS J. Jm. Lee & Son 300.4th st N E	

1900

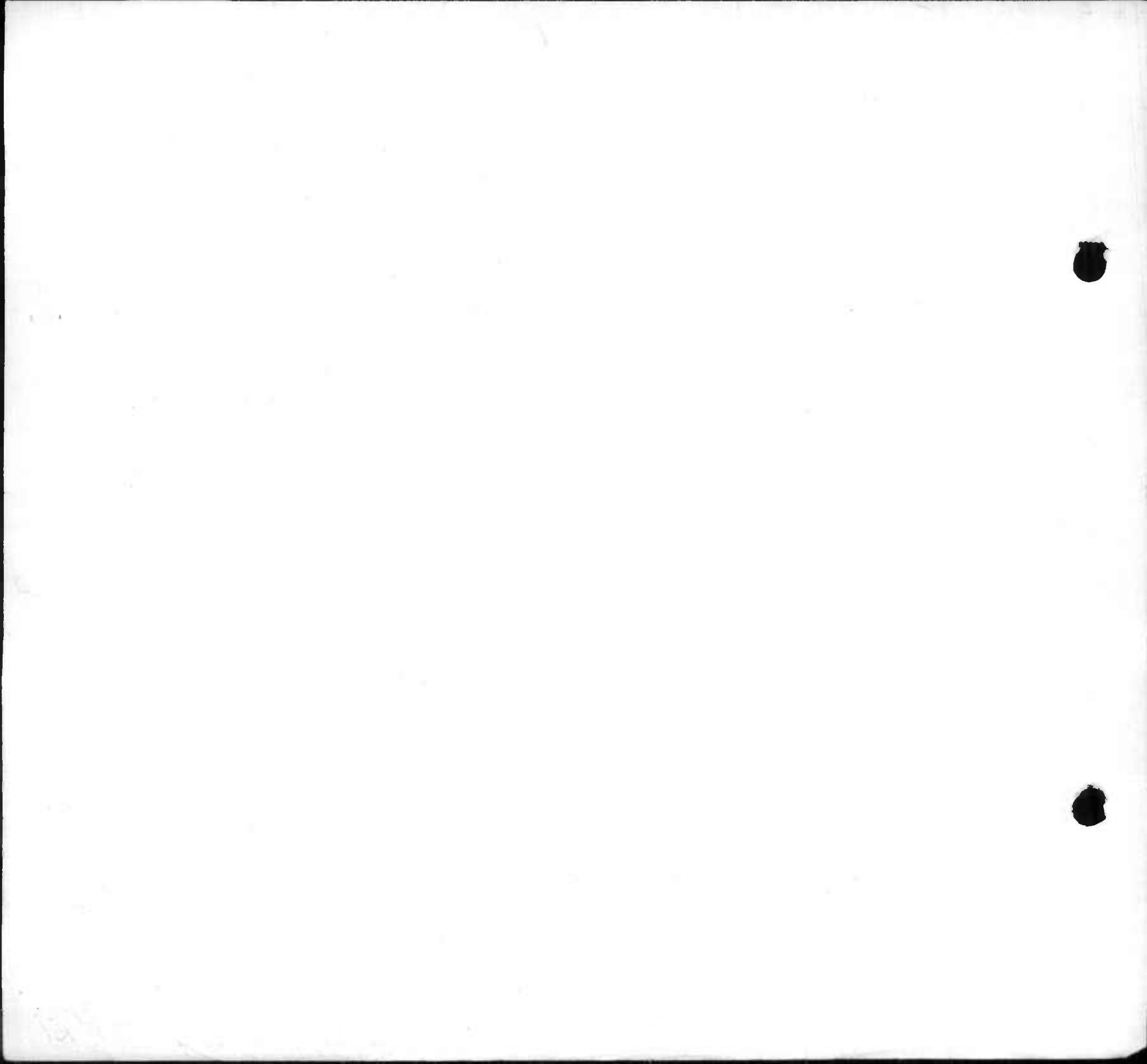
W. A. D. L. E. W. & S. B. D. L. E. W.

W. A. D. L. E. W. & S. B. D. L. E. W.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

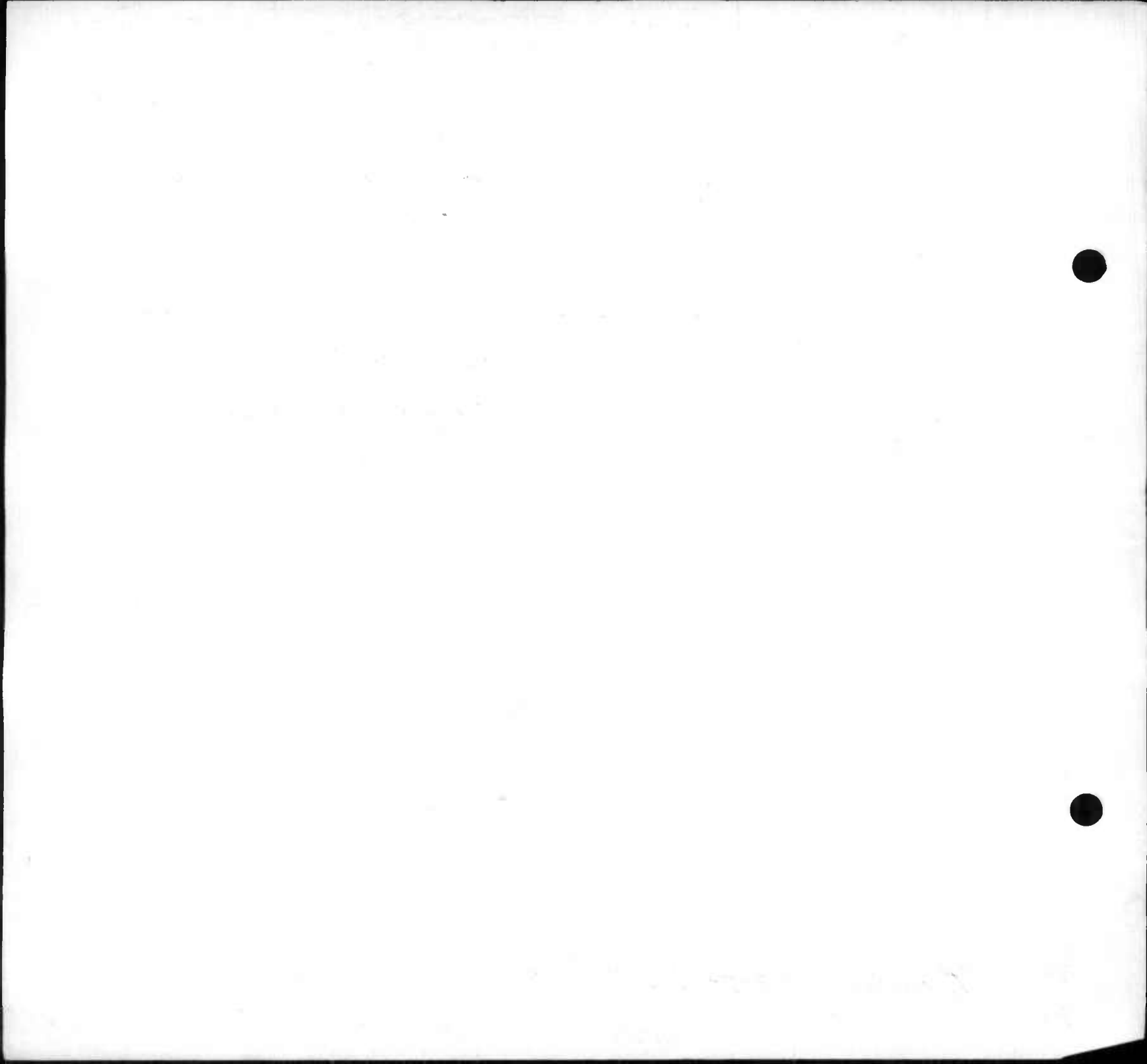
BALTIMORE CITY HEALTH DEPARTMENT				70 6762		REG. NO. 70 6762	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) PORFIRIO LARDIZABAL				2. DATE AND HOUR OF DEATH 7/5/70 9:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE HONDURAS , B. COUNTY CENTRAL AMERICA C. CITY OR TOWN SAN PEDRO SULA D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5 AVE. S. O. #24			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 15, 98		9. AGE (in years last birthday) 71	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RANCHER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HONDURAS		12. CITIZEN OF WHAT COUNTRY? HONDURAS C.A.	
13. FATHER'S NAME MANUEL E. LARDIZABAL				14. MOTHER'S MAIDEN NAME VICTORIA ALTAMIRANO			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE		17. INFORMANT JUANA DE LARDIZABAL		ADDRESS SAME	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I Pneumonia GLIOBLASTOMA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 10 mo			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 6/19		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GLIOBLASTOMA		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 6/8/70 19 70 to 7/4 19 70 that (1) (we) lost the deceased alive on 7/5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Melvin H. Epstein M.D.				23B. DATE SIGNED 7/5/70		23C. PHYSICIAN'S NAME (Type) MELVIN H. EPSTEIN M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/70		24C. NAME of CEMETERY or CREMATORY HONDURAS CEMETERY		24D. LOCATION (City, town, or county) (State) SAN PEDRO SULA HONDURAS B.C.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Taber, R.D.		25C. FUNERAL DIRECTOR MITCHELL WIEDEFELD HOME		ADDRESS 6500 Rd 139 Baltimore, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

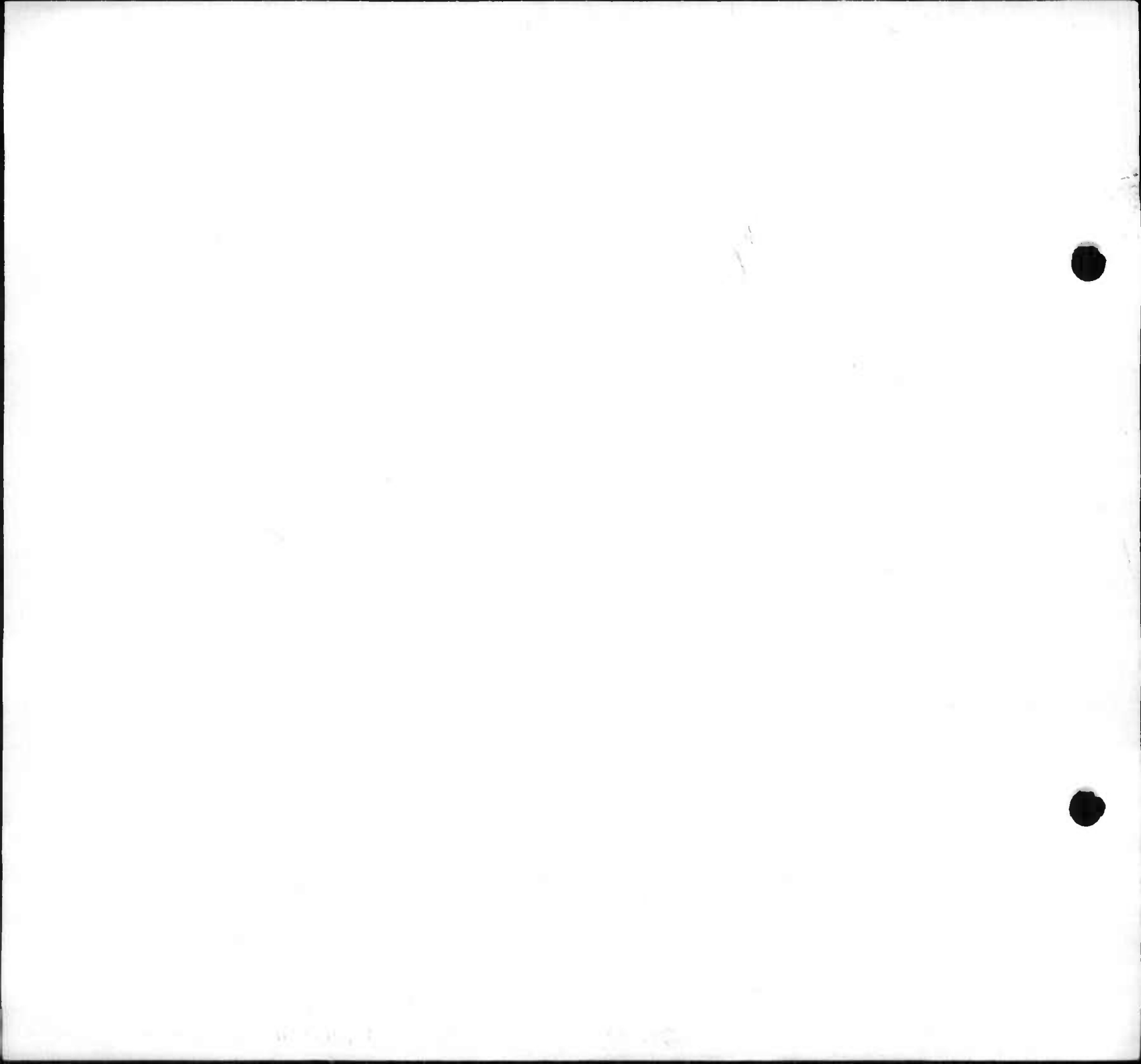
W-300		70 6763		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6763	
1. NAME OF DECEASED (Type or Print) ELIZABETH WHITE				2. DATE AND HOUR OF DEATH 7.4.70 2³⁶ PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL of BALTIMORE				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1608					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL of BALTIMORE				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 774 Granthly St.					
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2.4.07	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CHEMICAL CO		11. BIRTHPLACE (State or foreign country) GREENVILLE N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LESTER DOGAN				14. MOTHER'S MAIDEN NAME ELIZABETH CUNERTON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT OZELL WHITE 774 GRANTLEY ST		ADDRESS			
18. 450 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH PULMONARY EMBOLUS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HEART DISEASE									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (he) (this hospital) attended the deceased from 7.4.70 19__ to 7.4.70 19__ that (he) (we) last saw the deceased alive on 7.4.70 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE M. Bodenheim M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7.4.70			
23C. PHYSICIAN'S NAME (Type) M. BODENHEIMER, M.D.				23D. ADDRESS Sinai					
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 7.9-70		24C. NAME of CEMETERY or CREMATORY Flat Rock Bapt Church		24D. LOCATION (City, town, or county) (State) GREENVILLE S.C.			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Franklin A. Hays		ADDRESS 3540 Cilemon St			



FUNERAL DIRECTOR: IMPORTANT

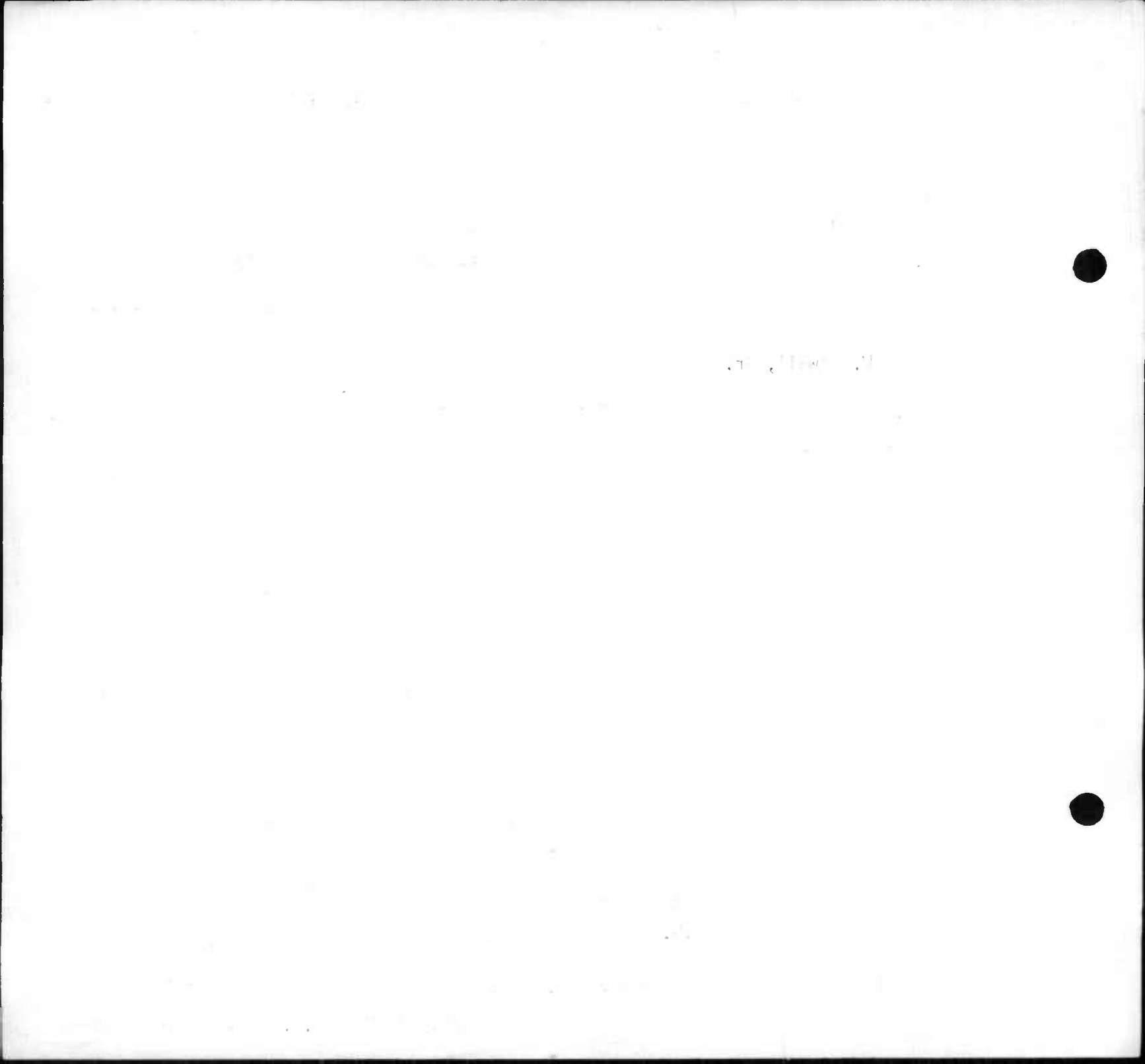
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-360		70 6764		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6764	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) WILLIAM JETER		2. DATE AND HOUR OF DEATH 7-4-70 16:10 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1606			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MD.				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER B 3019 HARLEM AVE			
5. SEX M	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-1900	9. AGE (In years lost birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME -				14. MOTHER'S MAIDEN NAME -			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 248-26-7004		17. INFORMANT Niece - MARIE WASHINGTON		ADDRESS	
18. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days	
				(B) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:		MONTHS	
				(C) ASCVD		YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary Embolism						YEARS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-4 19 70 to 7-4 19 70 that (I) (we) last saw the deceased alive on 7-4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Angelita A. Topacio MD				23B. DATE SIGNED 7-8-70		23C. PHYSICIAN'S NAME (Type) ANGELITA TOPACIO, MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/8/70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR Morton & Dyett F. H		ADDRESS 1701 Laurens St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
P-400		70 6765		70 6765	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
James Wesley Powell, Jr.			July 2, 1970 5:43 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Baltimore City Hospitals			Maryland		
4940 Eastern Avenue			C. CITY OR TOWN		
Baltimore, Maryland 21224			Baltimore		
			D. INSIDE CITY LIMITS?		
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			1825 Druid Hill Avenue 21217		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months: Days: Hours: Min.
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-13-01	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				Maryland, Baltimore	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
James W. Powell, Sr.			Mary Jackson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No.		216-03-8983A		BCH: Records 4940 Eastern Avenue Baltimore, Maryland 21224	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			IRREVERSIBLE hypotension 2 1/2 hrs		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			overwhelming pneumonia - post sepsis 2 weeks		
			(C) carcinoma of the esophagus		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Rt Hemiplegia 2 days		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
3 6/18/70		carcinoma of esophagus		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 6/4 1970 to 7/2 1970 that (I) (we) last saw the deceased alive on 7/2/70 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
W. L. Mc Gavran III M.D.			7/2/70		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
W. L. Mc Gavran III M.D.			Baltimore City Hospitals		
			4940 Eastern Avenue Baltimore, Maryland 21224		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		7-6-70		Carver Mem. Park	
				Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 7 1970		Robert E. Taylor, M.D.		MORTON & DYETT F.H. 1701 Laurens Street	



41-47-15 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6766	
BIRTH NO. 2-535		70 6766			
1. NAME OF DECEASED (Type or Print) Linton, Eugene		2. DATE AND HOUR OF DEATH 7/2/70 12:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4940 EASTERN AVE. 21224 Baltimore City, Maryland		A. STATE Maryland B. COUNTY Baltimore			
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1437 Holbrook St. 21202					
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/30	9. AGE (In years last birthday) 40	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sumpter, South Carolina	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Edgar Linton			
14. MOTHER'S MAIDEN NAME unk (Gertrude McBerry)		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			
16. SOCIAL SECURITY NO.		17. INFORMANT 4940 EASTERN AVE BCH RECORDS. BALTO, MD 21224			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE Due to, or as a consequence of: Pulmonary embolus 1 hr.			
ANTECEDENT CAUSES		(B) Chronic obstructive pulmonary disease 8 yrs			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Congestive heart failure - chronic myocardial			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/10 19 20 to 7/2 19 20 that (I) (we) last saw the deceased alive on 7/1 19 20 11 AM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael W. Popen, M.D.		23B. DATE SIGNED 7/2/70		23C. PHYSICIAN'S NAME (Type) Michael W. POZEN	
23D. ADDRESS 4940 EASTERN AVE, 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/2/70		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Faller, Jr.		25C. FUNERAL DIRECTOR Morton E. Dyett F.H. 1701 Laurens	

1-35.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. [REDACTED]
<p>H-520 10 6767</p> <p>BIRTH NO. HAINES.</p> <p>1. NAME OF DECEASED (Type or Print) HELEN.</p>		<p>2. DATE AND HOUR OF DEATH 3-2-70 / 4:07 PM.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p style="font-size: 1.5em;">THE JOHNS HOPKINS HOSPITAL</p> <p style="font-size: 2em;">33</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE FLORIDA B. COUNTY FLORIDA</p> <p>C. CITY OR TOWN Tallahassee D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER 416 BEARD ST.</p>		
<p>5. SEX FEMALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 10-23-09</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 1.5em;">Librarian</p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 1.5em;">Virginia</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="font-size: 1.5em;">U.S.A.</p>
<p>13. FATHER'S NAME</p> <p style="font-size: 1.5em;">BURTON C. HAINES</p>		<p>14. MOTHER'S MAIDEN NAME</p> <p style="font-size: 1.5em;">BESSIE DORMAN</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="font-size: 1.5em;">No</p>		<p>16. SOCIAL SECURITY NO.</p> <p style="font-size: 1.5em;">266-76-8951</p>		<p>17. INFORMANT ADDRESS</p> <p style="font-size: 1.5em;">Mr Robert L Meyers 2726 Alden Rd Balto. Md</p>
<p>18. CAUSE OF DEATH</p>				
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)</p> <p style="font-size: 1.5em;">(A) IMMEDIATE CAUSE possible Septic Shock</p> <p style="font-size: 1.5em;">(B) CV Tract infection; Aspiration pneumonia</p> <p style="font-size: 1.5em;">(C) postop. occlusive Myocardium</p>				
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				
<p>II</p>				
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>				
<p>19A. DATE OF OPERATION 6-25-70</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Acoustic Neuroma</p>		<p>20A. AUTOPSY? (Yes or No) NO</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>
<p>22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>				
<p>23A. SIGNATURE</p> <p style="font-size: 2em;"><i>Hamid</i></p>		<p>23B. DATE SIGNED</p>		<p>23C. PHYSICIAN'S NAME (Type)</p> <p style="font-size: 1.5em;">HAMID</p>
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 1.5em;">Burial</p>		<p>24B. DATE</p> <p style="font-size: 1.5em;">7/7/70</p>		<p>24C. NAME OF CEMETERY or CREMATORY</p> <p style="font-size: 1.5em;">Elmwood</p>
<p>24D. LOCATION (City, town, or county) (State)</p> <p style="font-size: 1.5em;">Norfolk, Virginia</p>		<p>25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970</p>		
<p>25B. NAME OF REGISTRAR</p> <p style="font-size: 1.5em;">Robert E. [REDACTED]</p>		<p>25C. FUNERAL DIRECTOR ADDRESS</p> <p style="font-size: 1.5em;">Leonard J. Ruck I. c. Baltimore, Maryland</p>		

[REDACTED]

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9.

10.

11.

12. The twelfth part is a summary of the work done during the year.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-160		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6768	
1. NAME OF DECEASED (Type or Print) Bernard L Hooper				2. DATE AND HOUR OF DEATH July 4, 1970 3 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED Union Memorial Hospital 7-13-70				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 903			
5. SEX Male				6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/20/1919				9. AGE (In years last birthday) 51		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Zenus Barnum Hooper				14. MOTHER'S MAIDEN NAME Alice Marie Boose			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) yes W.W. II				16. SOCIAL SECURITY NO. 218-01-0180		17. INFORMANT Hooper Lillian G. Landon same ADDRESS	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction (B) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One hour	
19A. DATE OF OPERATION 7-4-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-4-70 to 7-4-70 and that (I) (we) lost saw the deceased alive on 7-4-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George N. Agapitos, M.D.				23B. DATE SIGNED 7-4-1970		23C. PHYSICIAN'S NAME (Type) George N Agapitos M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/7/70		24C. NAME of CEMETERY or CREMATORY Parkwood Cem.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970				25B. NAME OF REGISTRAR Robert J. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J Ruck Inc.	
				24D. LOCATION Balto. Md.		ADDRESS Baltimore, Maryland	

D-100

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6769

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

6769

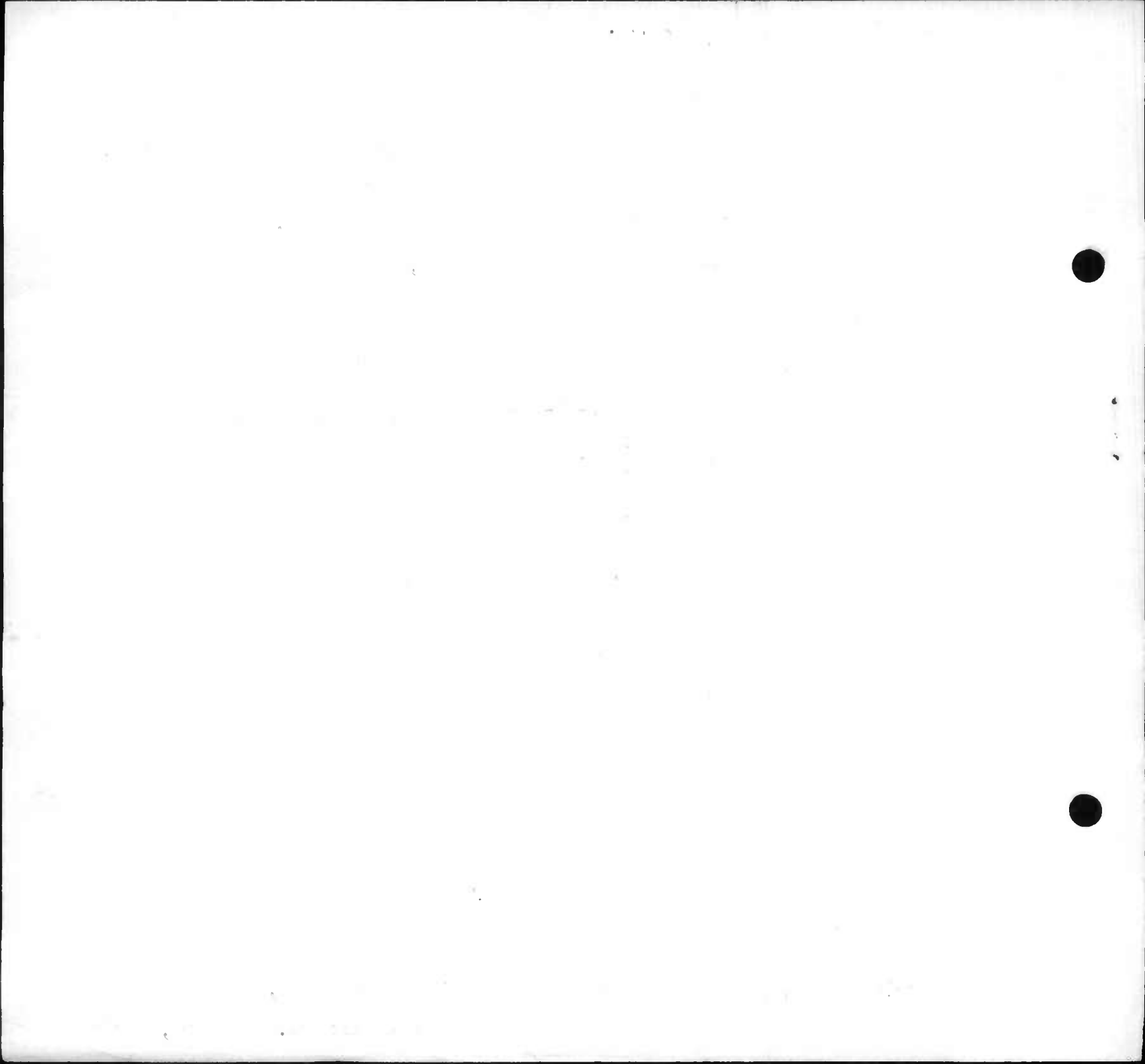
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Paul ROLAND DUFF Sr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 5 1970 2:15 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2731			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. CITY OR TOWN Balto.
10. AGE (In years last birthday) 68		11. STREET AND NUMBER 4103 Eierman Ave.	
12. BIRTHPLACE (State or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Case Maker		15. MOTHER'S MAIDEN NAME Anna Dennis	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs Esther Duff		ADDRESS Same	
19. CAUSE OF DEATH 412.4 Arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 8		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) OF INJURY		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Isidore Mihalakis, M.D. DATE SIGNED: 7-5-70 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/70	
24C. NAME of CEMETERY or CREMATORY Gardens Of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Leonard J. Buck Inc.		ADDRESS Baltimore, Maryland	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-512 70 6770		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6770	
BIRTH NO. Thompson Lillian		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Thompson Lillian Elinore		2. DATE AND HOUR OF DEATH July 4, 1970 1 12:12 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Md. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 8. COUNTY Baltimore Maryland 21224 2747 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2918 Louise Ave.			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 17, 1905	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John W Manly		14. MOTHER'S MAIDEN NAME Freda Becker		12. CITIZEN OF WHAT COUNTRY USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 212-07-1368		17. INFORMANT Patient's Chart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E897X CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration of amesic (B) DUE TO, OR AS A CONSEQUENCE OF: Sepsis (C) DUE TO, OR AS A CONSEQUENCE OF: 45% Burn DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Atrial Fibrillation & Congestive Heart Failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min 48 hrs 3 wks (?) 3 Years					
19A. DATE OF OPERATION 0 NA		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) 21D. TIME OF INJURY (APPROX.) 6-11-70		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Home 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home 21F. HOW DID INJURY OCCUR? Slipped down on icy sidewalk 2198 Louise Ave, Baltimore, Md.	
22. I certify that (I) (this hospital) attended the deceased from June 11, 1970 to July 4, 1970 that (I) (we) last saw the deceased alive on July 4, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James Heroy		23B. DATE SIGNED 7/4/70		23C. PHYSICIAN'S NAME (Type) James Heroy	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/7/70		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	
24D. LOCATION Baltimore, Maryland		24E. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24F. LOCATION Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Leonard U Ruck Inc.		25C. FUNERAL DIRECTOR Leonard U Ruck Inc. Baltimore, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6771	
C-54070 6771				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) John A. CONNELLY			2. DATE AND HOUR OF DEATH 7-5-70 1:40 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2002		
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hosp. of Md.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 2700 W Franklin St.					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-92	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) un employed CLEANER & DYER			11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John A. CONNELLY			14. MOTHER'S MAIDEN NAME ROSE CUSACK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I			16. SOCIAL SECURITY NO. 216-01-0967-A		
17. INFORMANT Mr. John E. CONNELLY, 7261 Holabird AVE			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Intestinal obstruction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Atherosclerotic cardiovascular disease					
19A. DATE OF OPERATION 0 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-4-1970 to 7-5-1970 , that (I) (we) last saw the deceased alive on 7-5-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sunan Vongkasemsiri			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-5-70
23C. PHYSICIAN'S NAME (Type) SUNAN VONGKASEMSIRI			23D. ADDRESS Lutheran Hosp. of Md.		
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/70		24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTO. MD.					
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR L.T. RUCK-INS	
ADDRESS 5335 Hartford Rd					

2-2-11

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-355 70 6772		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6772	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Bateman, Laura M</i>		2. DATE AND HOUR OF DEATH <i>7/3/70 11:45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>4 Bon Secours Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>21223</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bon Secours Hospital</i>		E. STREET AND NUMBER <i>1451 North Howard Ave.</i>		14 So. Arlington Ave.	
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/2/85</i>	9. AGE (in years last birthday) <i>84</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Hyles, William</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-54-3421</i>		17. INFORMANT <i>B. Rehman RN</i>	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Failure</i> <i>old age</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/3/70</i> 19 <i>70</i> to <i>7/3</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>7/3</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Tawee MD</i>		23B. DATE SIGNED <i>7-3-70</i>		23C. PHYSICIAN'S NAME (Type) <i>Tawee MD</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/6/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>	
24D. LOCATION <i>Anne Arundel Co., Maryland</i>		24E. CITY, town, or county <i>1500</i>		24F. STATE <i>1500</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Sabin, M.D.</i>		25C. FUNERAL DIRECTOR <i>Walters Funeral Home Pratt & Stricker</i>	
25D. ADDRESS <i>Streets 21223</i>		25E. CITY, town, or county <i>1500</i>		25F. STATE <i>1500</i>	

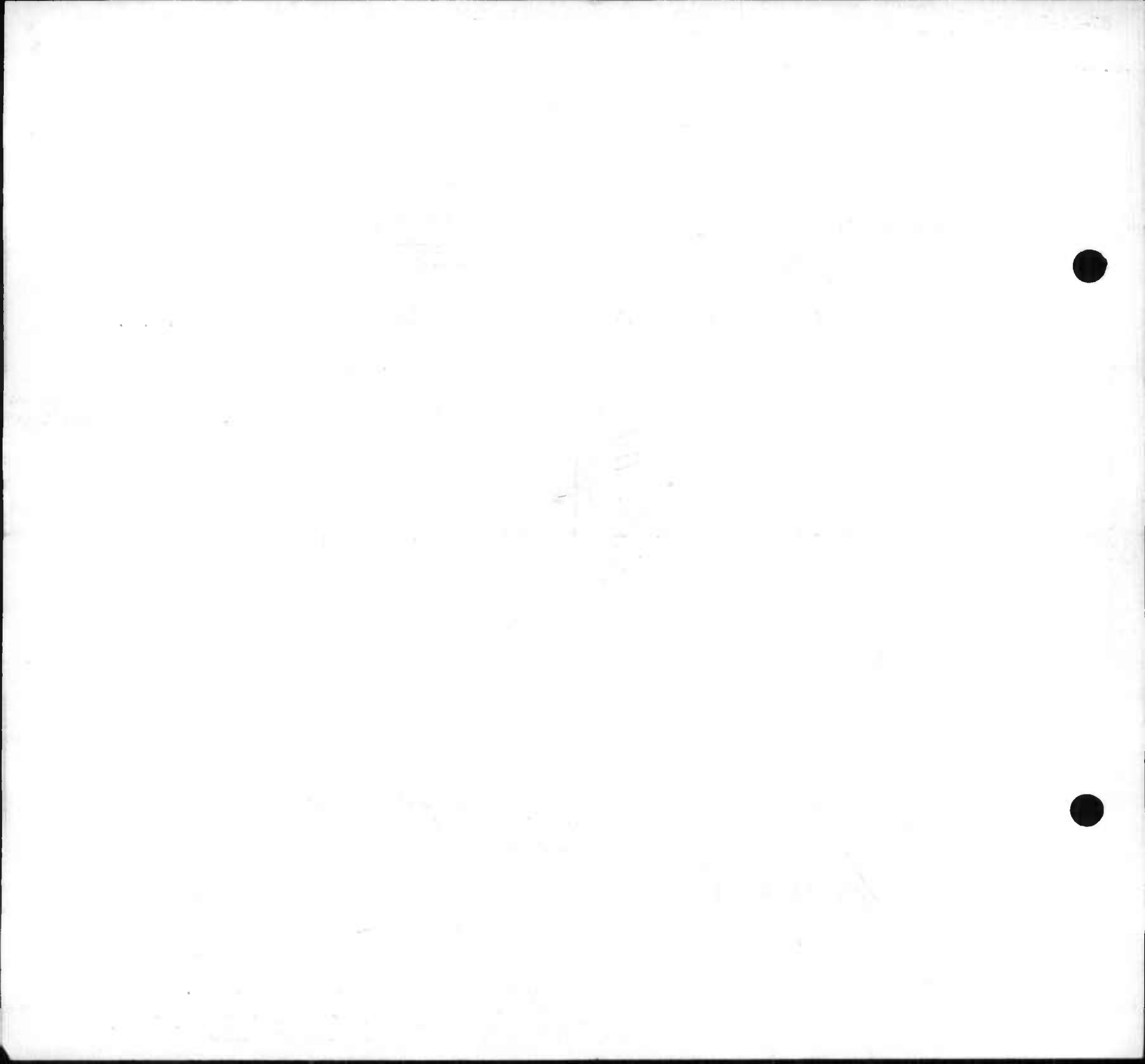
1880-1881

D.O.A.

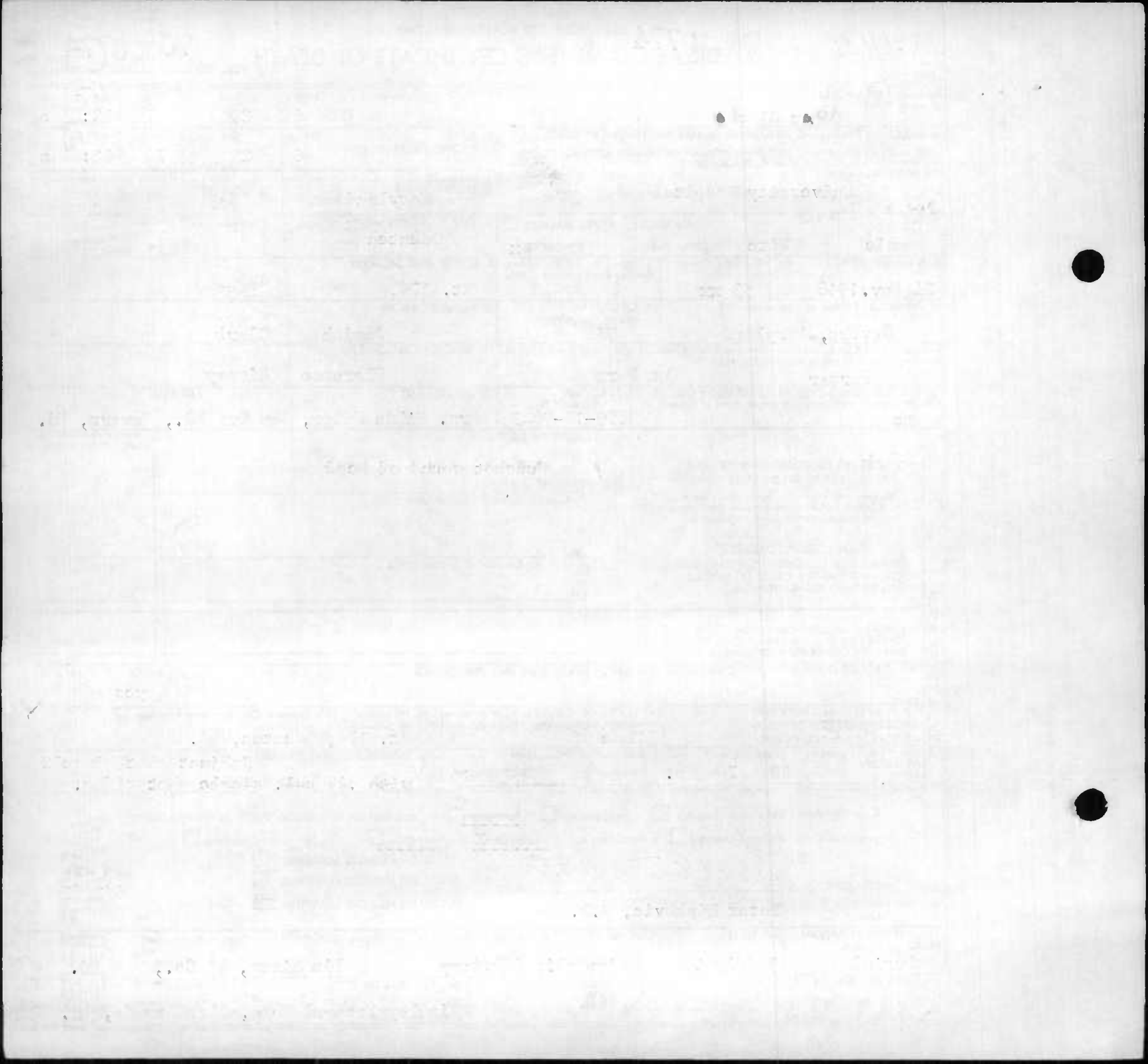
Released By Medical Examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 8-400 70 6773				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6773	
1. NAME OF DECEASED (Type or Print) Ellsworth JOHN RILEY				2. DATE AND HOUR OF DEATH 6.30.70 8:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2634			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 921 Horner's Lane 21205							
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-6-93	9. AGE (in years last birthday) 76	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-Laborer		10B. KIND OF BUSINESS OR INDUSTRY City Parks		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George Riley				14. MOTHER'S MAIDEN NAME Ann Speaks			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of)				16. SOCIAL SECURITY NO. 212-10-5801		17. INFORMANT ADDRESS BCH: Records 4940 Eastern Avenue Baltimore, Maryland 21224	
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH IMMEDIATE CAUSE Prob CVA DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day - yrs	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				congestive heart failure			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 6.24 1970 to 6.30 1970 that (H) (we) last saw the deceased alive on 6.24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James T. Corkins				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 6.30.70	
23C. PHYSICIAN'S NAME (Type) James T. Corkins				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/70		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Phyllis E. Fisher, R.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	



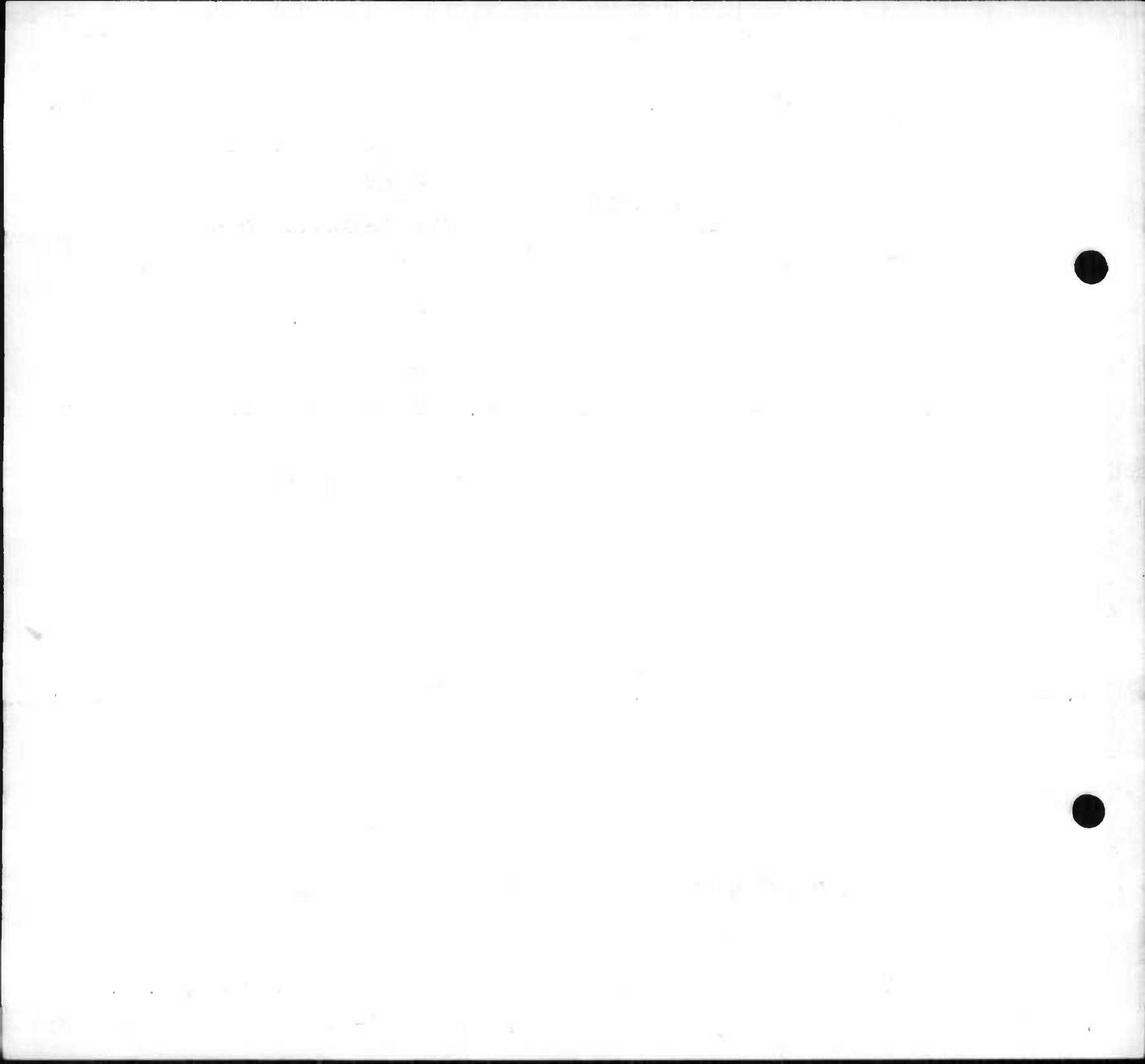
BALTIMORE CITY HEALTH DEPARTMENT											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
REG. NO. 70 6774											
BIRTH NO. C-462											
1. NAME OF DECEASED (Type or Print) Edgar Clark					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 29 70 12:01 a.m.						
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital					3. DATE PRONOUNCED DEAD Month Day Year Hour 6 29 70 12:01 a.m.						
6. SEX male					7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA		
9. DATE OF BIRTH 24 Nov. 1916			10. AGE (In years last birthday) 53		11. BIRTHPLACE (State or foreign country) Severn, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			C. CITY OR TOWN Odenton	
13. FATHER'S NAME Josiah Clark			14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			15. MOTHER'S MAIDEN NAME Florence Disney			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			17. SOCIAL SECURITY NO. 579-12-9623			18. INFORMANT Mrs. Hilda Upton			ADDRESS New Cut Rd., Severn, Md.		
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2			20B. CONDITION FOR WHICH OPERATION WAS PERFORMED							21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rt. 170, Odenton, Md.				22D. TIME OF INJURY (APPROX.) 6 28 70 p.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			22F. HOW DID INJURY OCCUR? Subject shot himself with .22 cal. single shot rifle.								
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/30/70											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 3 July '70		24C. NAME of CEMETERY or CREMATORY Friendship Cemetery			24D. LOCATION (City, town, or county) (State) Linthicum, AA Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			25C. FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.					



FUNERAL DIRECTOR: IMPORTANT

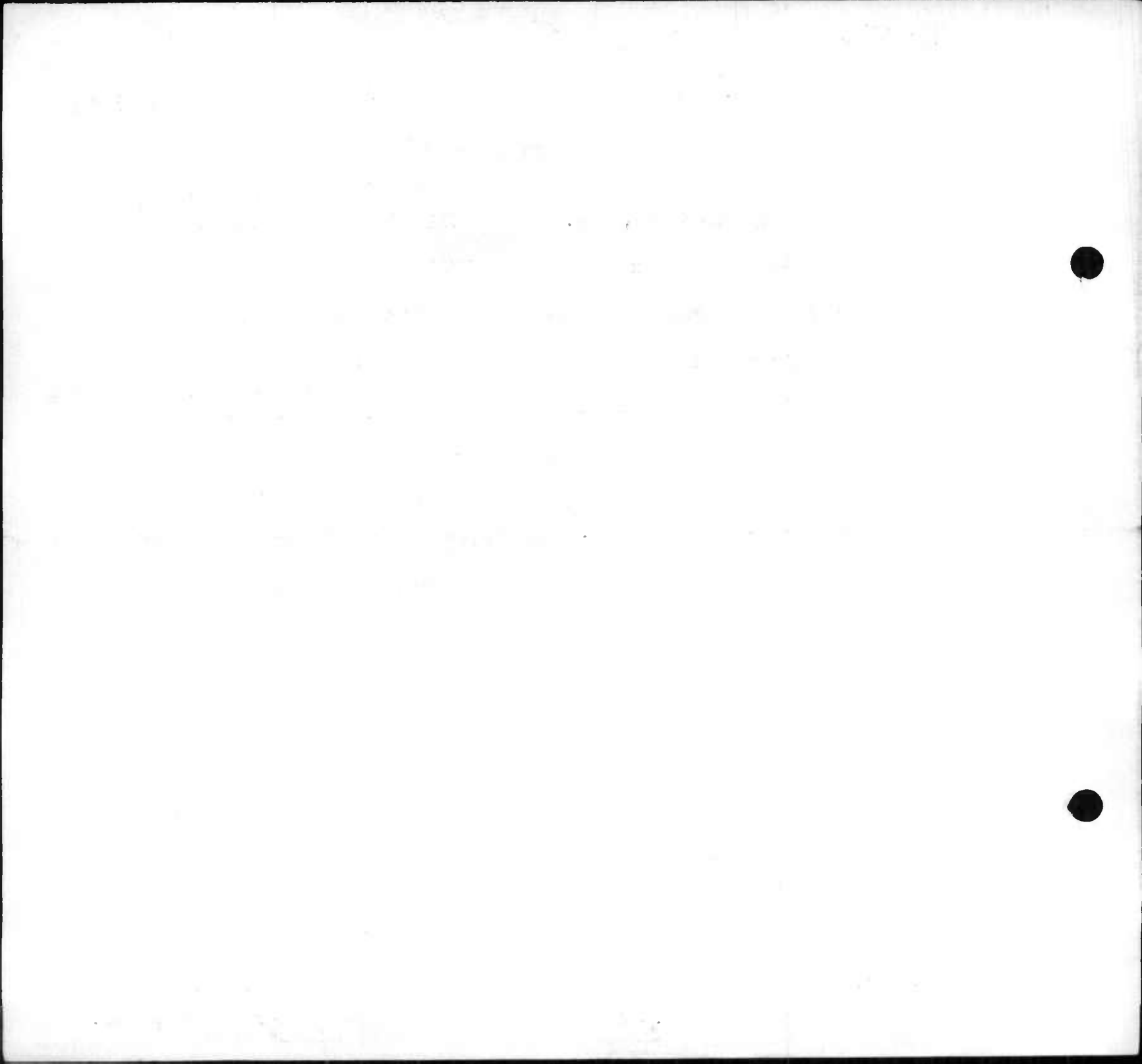
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530 70 6775		BALTIMORE CITY HEALTH DEPARTMENT		70 6775	
BIRTH NO. 70-07039		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) SMYTH, Whitney		2. DATE AND HOUR OF DEATH 7/1/70 4:35 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER 1337 Valley Brook Road			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/70	9. AGE (In years last birthday) 2 15	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME Whitney Smyth		14. MOTHER'S MAIDEN NAME Sharon Myers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Whitney Smyth 1337 Valley Brook	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Apeptic Spell DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David Valle M.D.		23B. DATE SIGNED 7/1/70		23C. PHYSICIAN'S NAME (Type) David Valle, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/3/70		24C. NAME OF CEMETERY or CREMATORY Hillside Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Mitchell Wiedefeld		25C. FUNERAL DIRECTOR ADDRESS Home 6500 York	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

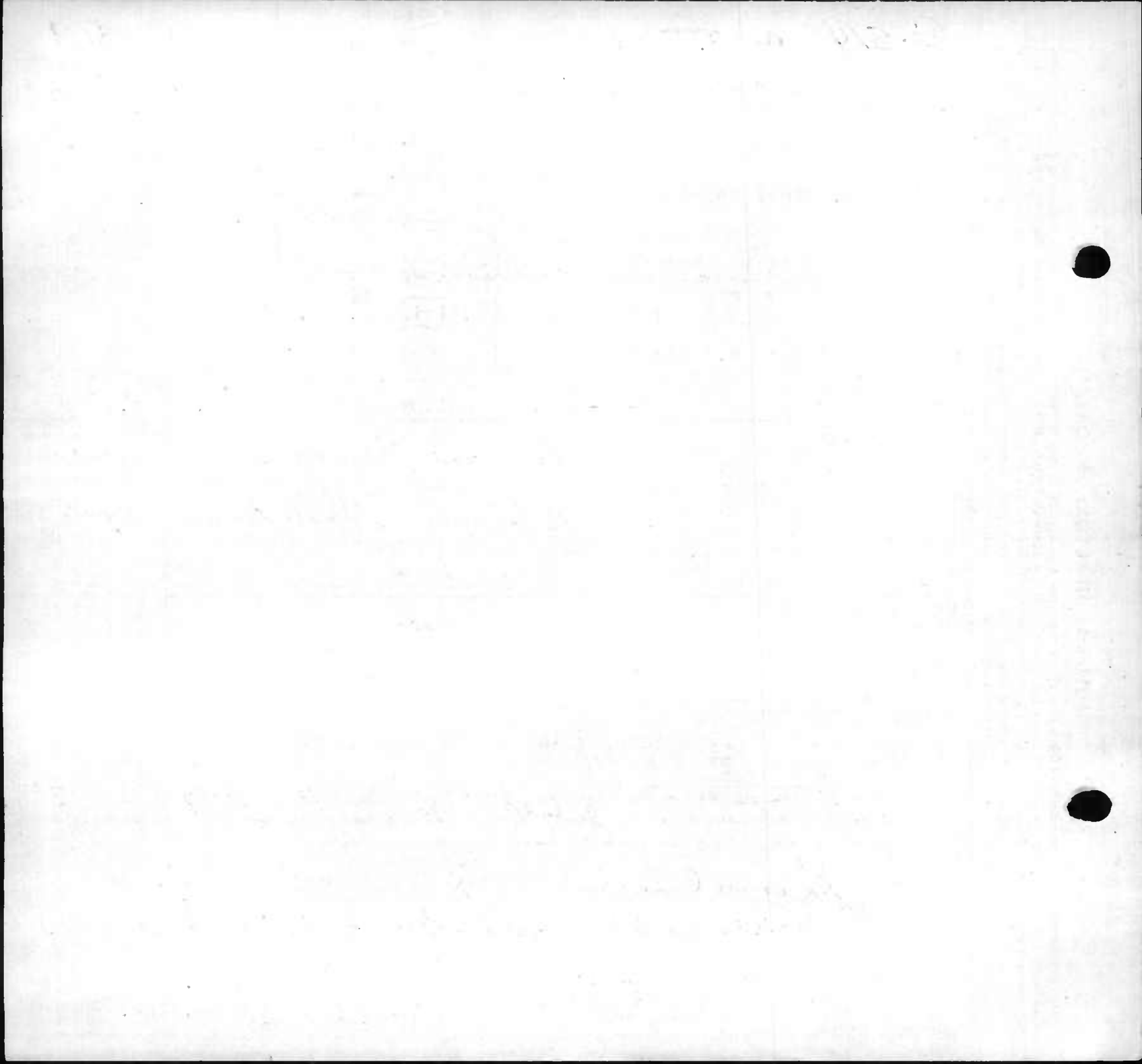
BIRTH NO. R-350		70 6776		BALTIMORE CITY HEALTH DEPARTMENT		70 6776	
1. NAME OF DECEASED (Type or Print) Ann Rose A. Roden				2. DATE AND HOUR OF DEATH 7/2/70 4:30 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 Mercy Hospital & Inc.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland 21224 B. COUNTY 2605			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital & Inc.				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 621 S. Tolna Street			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/12/07	
				9. AGE (In years last birthday) 63		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10B. KIND OF BUSINESS OR INDUSTRY Title Guarantee		11. BIRTHPLACE (State or foreign country) Austria x Baltimore, Md	
13. FATHER'S NAME Michael Bizek				14. MOTHER'S MAIDEN NAME Marie Riha			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 220-14-9195				16. SOCIAL SECURITY NO. 220-14-9195			
				17. INFORMANT 9664 Dundawan Rd. Clifton M. Roden, son, ADDRESS 21236			
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Massive Carcinomatosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: primary site to be determined (B) involving lymph nodes and liver DUE TO, OR AS A CONSEQUENCE OF: (C) with obstructive jaundice			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2 Nil		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Nil		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Nil		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? -		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (this hospital) attended the deceased from 5/24 19 70 to 7/2/70 19 70 that (I) (we) last saw the deceased alive on 4:30pm 7/2 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Pratima Bose M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/3/70.	
23C. PHYSICIAN'S NAME (Type) PRATIMA BOSE M.D.				23D. ADDRESS Mercy Hospital Balto. 21202			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/70		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

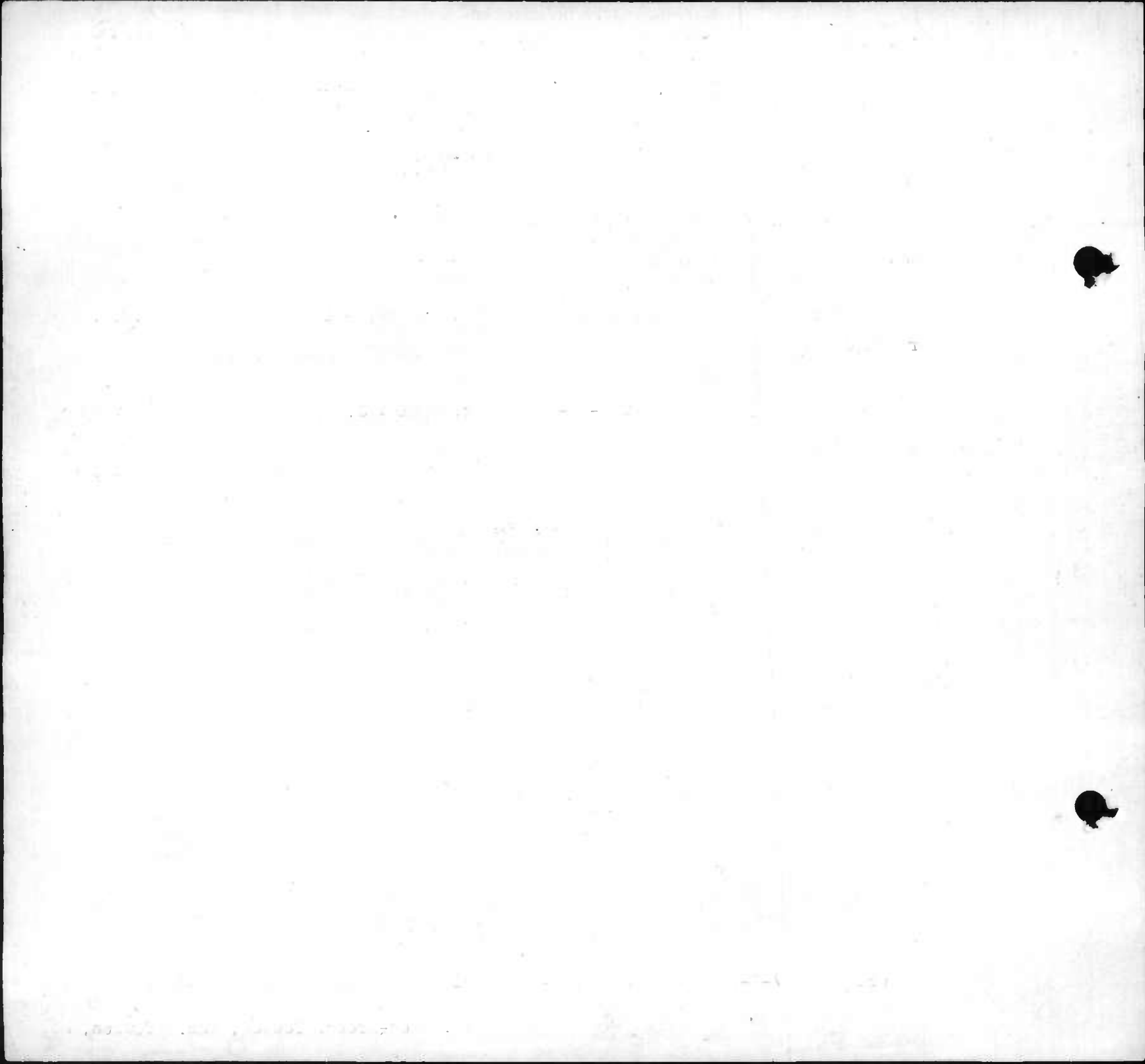
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6777	
C-514 70 6777		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Gertrude MARY CAMPBELL		JULY 3, 1970		7 ³⁰ A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
90 Mt. Sinai Nursing Home		Md., 21202		909	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		732 E. Preston St.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
female	white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4/4/84	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		at home		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
William R. Strickland		Emily Steinacker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		217-56-5334J1		39 Dunkirk Rd. 21212	
				Helen Loretta Carroll, dght.	
18. <u>412.3</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		w/et	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		1 year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>none</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>none</u>			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
<u>0</u>		<u>none</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 30</u> 19 <u>70</u> to <u>July 3</u> 19 <u>70</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>July 30</u> 19 <u>70</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel Levin</u>				23B. DATE SIGNED <u>7/3/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u>				23D. ADDRESS <u>M-D 6101 PARK HEIGHTS AVE, BALTO-15 MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	7/6/70	Woodlawn Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Schimunek Funeral Home, Inc. 3331 Brehms Lane</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
70 6778 CERTIFICATE OF DEATH					REG. NO. 70 6778									
BIRTH NO. P-225					1. NAME OF DECEASED (Type or Print) MARIE M. PESSAGNO					2. DATE AND HOUR OF DEATH 7-1-70 5:30 P M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 100 W. COLDSRING LANE					2711				
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-6-09		9. AGE (In years last birthday) 60		If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker					10B. KIND OF BUSINESS OR INDUSTRY Own Home					11. BIRTHPLACE (State or foreign country) Columbus, Ohio				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Francisco SERIO					14. MOTHER'S MAIDEN NAME Gonzaga Serio				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 213-48-1883					17. INFORMANT Dr. Daniel J. Pessagno				
18. 211.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANEMIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) INTRA ABDOMINAL BLEED (C) GASTRIC POLYPS					19. qm ⊖ SEPTICEMIA OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 6/30/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTRA ABD BLEED			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR? -				
22. I certify that (I) (this hospital) attended the deceased from 6/30 19 70 to 7/1 19 70 , that (I) (we) last saw the deceased alive on 7/1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Larry Koep					23B. DATE SIGNED 7/1/70					23C. PHYSICIAN'S NAME (Type) LARRY KOEP				
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL					23E. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc.					23F. ADDRESS Towson, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-70		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial					24D. LOCATION (City, town, or county) (State) Timonium, Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970					25B. NAME OF REGISTRAR Robert E. Taylor					25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Inc.				



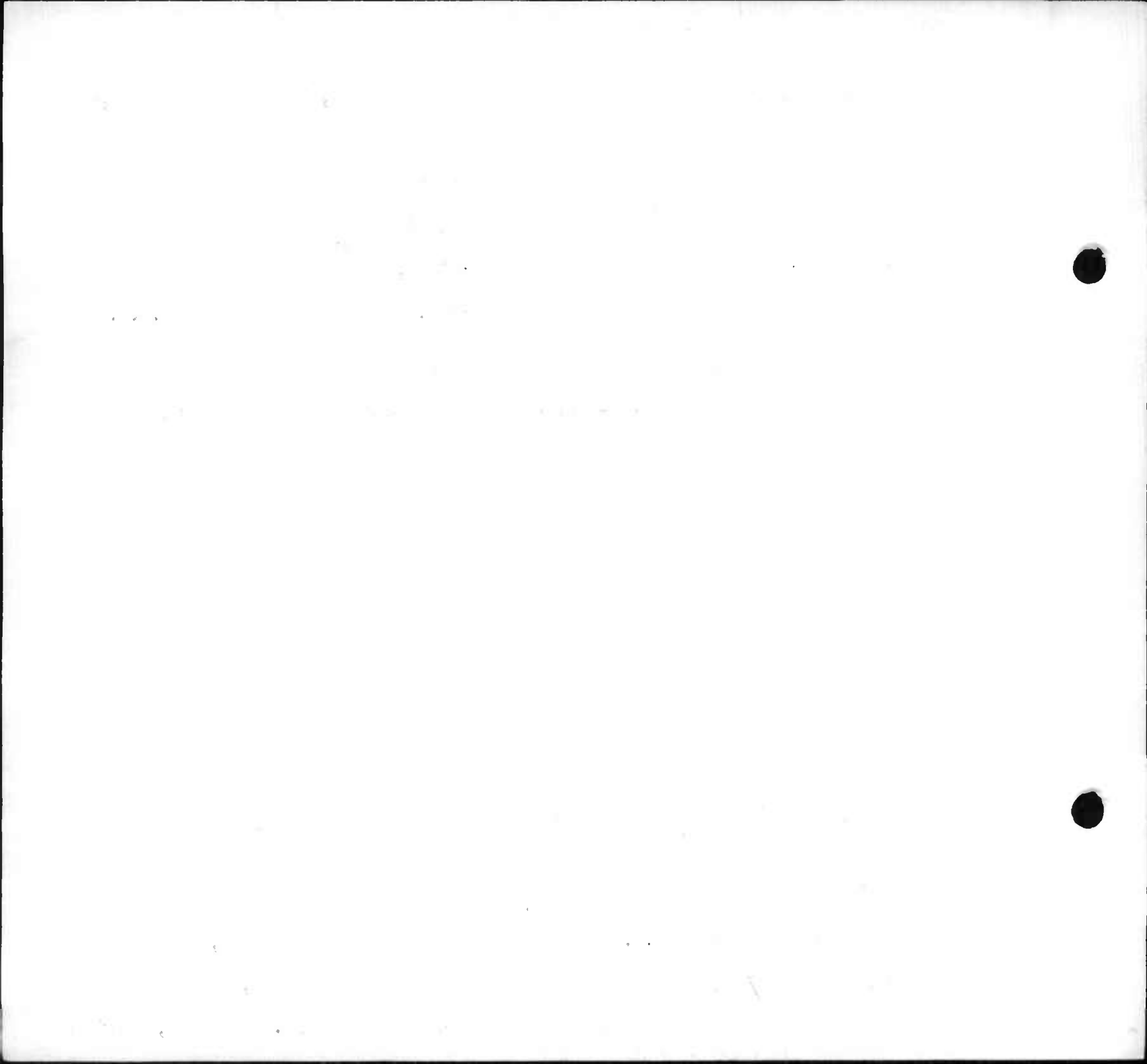
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">M-220 70 6779</p> <p style="font-size: 18pt; margin: 0;">BIRTH NO.</p>		<p style="font-size: 24pt; margin: 0;">70 6779</p> <p style="font-size: 18pt; margin: 0;">REG. NO.</p>	
<p style="font-size: 24pt; margin: 0;">M-220 70 6779</p> <p style="font-size: 18pt; margin: 0;">BIRTH NO.</p>		<p style="font-size: 24pt; margin: 0;">70 6779</p> <p style="font-size: 18pt; margin: 0;">REG. NO.</p>	
<p>1. NAME OF DECEASED (Type or Print)</p> <p style="text-align: center; font-size: 18pt;">LENORE NICHOLS MC GEOCH</p>		<p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center;">July 5, 1970</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If not in hospital or institution, give street address or location)</p> <p style="text-align: center; font-size: 18pt;">7-13-70</p> <p style="text-align: center;">Bolton Hill Nursing Home</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE: Maryland B. COUNTY: Baltimore</p> <p>C. CITY OR TOWN: Towson D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER: 20 Lambourn Road</p>	
<p>5. SEX</p> <p>female</p>	<p>6. RACE</p> <p>caucasian</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p> <p>March 12, 1893</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>homemaker</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p>home</p>	<p>11. BIRTHPLACE (State or foreign country)</p> <p>Maryland</p>
<p>13. FATHER'S NAME</p> <p>Edward Warren Nichols, Sr.</p>		<p>14. MOTHER'S MAIDEN NAME</p> <p>Agnes Lillian Anzmann</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p> <p style="text-align: center;">-213-10-1371D</p>	<p>17. INFORMANT</p> <p>E. Warren Nichols, Same as # 4</p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">I</p> <p style="text-align: center;">4123</p> <p style="text-align: center;">SS#213-01-1371D</p> <p style="text-align: center;">CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE: Congestive heart failure</p> <p>(B) arteriosclerotic heart disease</p> <p>(C) ---</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>several yrs.</p> <p>several yrs.</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No)</p>
<p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>
<p>22. I certify that (I) (this hospital) attended the deceased from 12-23 1966 to 7-5- 1970, that (I) (we) last saw the deceased alive on 7-4- 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p style="text-align: center;">E. Ellsworth Cook M.D.</p>		<p>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p>	<p>23B. DATE SIGNED</p> <p style="text-align: center;">7-6-70</p>
<p>23C. PHYSICIAN'S NAME (Type)</p> <p>E. Ellsworth Cook, M. D.</p>		<p>23D. ADDRESS</p> <p>2431 Maryland Avenue, Baltimore, Maryland</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>Removal</p>	<p>24B. DATE</p> <p>7-6-1970</p>	<p>24C. NAME OF CEMETERY or CREMATORY</p>	<p>24D. LOCATION (City, town, or county) (State)</p> <p>Orlando, Fla.</p>
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p>JUL 7 1970</p>	<p>25B. NAME OF REGISTRAR</p> <p>Robert E. Talley</p>	<p>25C. FUNERAL DIRECTOR</p> <p>Wm. Cook-Brooks</p>	<p>ADDRESS</p> <p>Towson, Maryland 2120</p>

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 6781

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ANNA RADER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 1, 1970 Hour 4:30 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year July 1, 1970 Hour 4:30 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1548	
9. DATE OF BIRTH April 7, 1880		10. AGE (In years lost birthday) 90	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 220 30 5847	
18. INFORMANT James Rothchild		ADDRESS 5750 Park Heights Ave	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E887 XI CAUSE OF DEATH (A) IMMEDIATE CAUSE Fracture of right femur DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7-1-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of leg	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) sidewalk	
22D. TIME OF INJURY (APPROX.) 6-26-70 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Near home on Garrison Boulevard		22F. HOW DID INJURY OCCUR? Fell on sidewalk	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 2, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 6, 1970	
24C. NAME OF CEMETERY or CREMATORY Western		24D. LOCATION (City, town, or county) (State) Edmondson Ave Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.	
25C. FUNERAL DIRECTOR Howard City		ADDRESS Harry Witzke Ellicott City	

STATE OF TEXAS - DEPARTMENT OF HEALTH

Form 100-1

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN

IN THE CITY OF _____

COUNTY OF _____

STATE OF TEXAS

DATE OF DEATH _____

TIME OF DEATH _____

PLACE OF DEATH _____

CAUSE OF DEATH _____

IMMEDIATE CAUSE OF DEATH _____

UNDERLYING CAUSE OF DEATH _____

OTHER CAUSE OF DEATH _____

MODE OF DEATH _____

DEGREE OF DEATH _____

CHARACTER OF DEATH _____

CLASS OF DEATH _____

TYPE OF DEATH _____

STAGE OF DEATH _____

PERIOD OF DEATH _____

SEASON OF DEATH _____

CLIMATE OF DEATH _____

LOCALITY OF DEATH _____

POPULATION OF DEATH _____

INDUSTRY OF DEATH _____

RELIGION OF DEATH _____

RACE OF DEATH _____

SEX OF DEATH _____

AGE OF DEATH _____

EDUCATION OF DEATH _____

OCCUPATION OF DEATH _____

WEALTH OF DEATH _____

POWER OF DEATH _____

INFLUENCE OF DEATH _____

CHARACTER OF DEATH _____

CLASS OF DEATH _____

TYPE OF DEATH _____

STAGE OF DEATH _____

PERIOD OF DEATH _____

SEASON OF DEATH _____

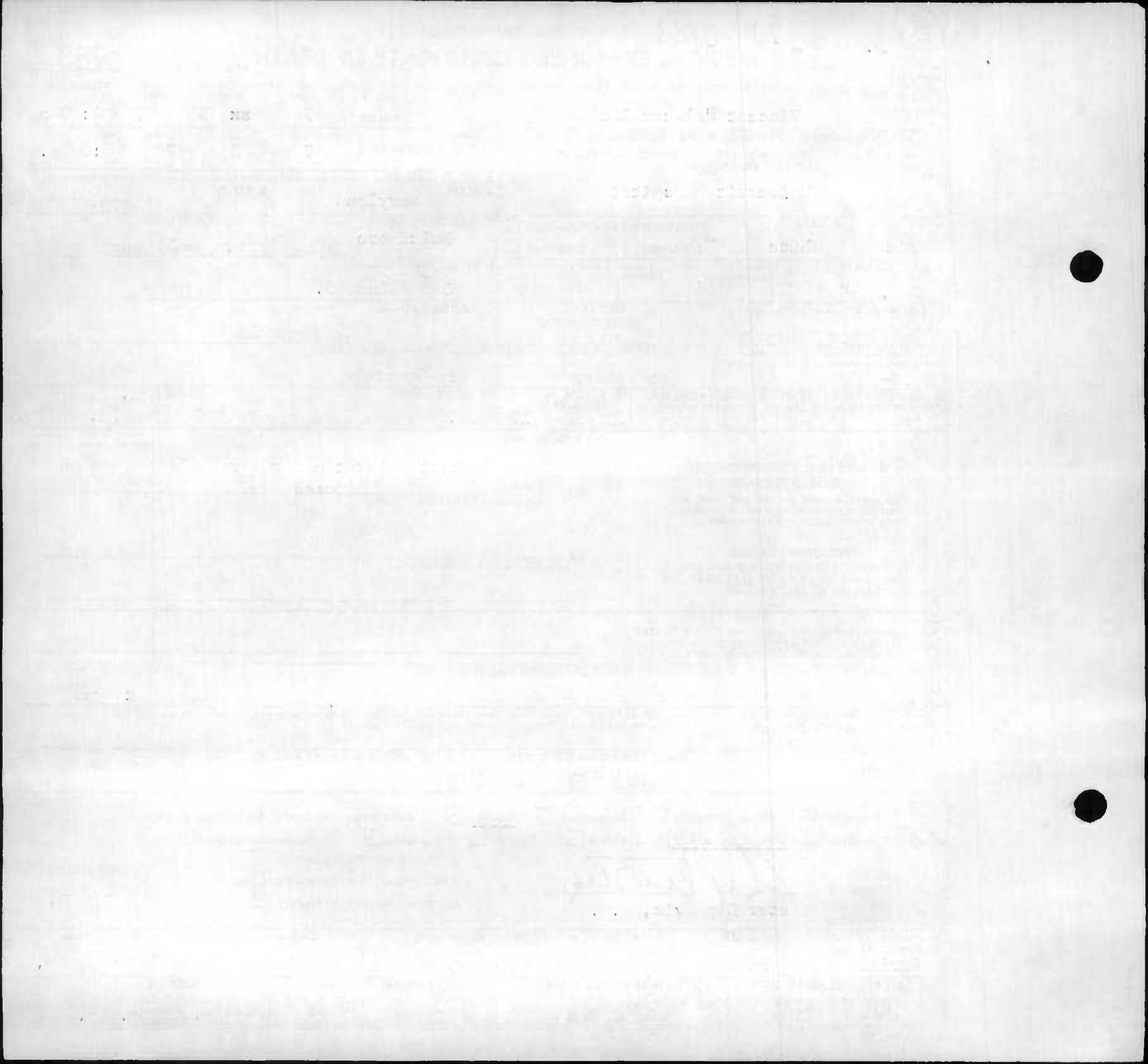
CLIMATE OF DEATH _____

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-200</u> <u>70</u> <u>6782</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70</u> <u>6782</u>	
1. NAME OF DECEASED (Type or Print) <u>WESS SR, WILLIAM ELBERT</u>		2. DATE AND HOUR OF DEATH <u>JULY 3, 1970</u> <u>1</u> <u>6:10 P</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST AGNES HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE COUNTY</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>5813 EDMONDSON AVENUE</u> <u>53-00</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>04 06 94</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED Buyer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BETHLEHEM STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>FREDERICK WESS</u>		14. MOTHER'S MAIDEN NAME <u>MARY (BRIDGETT)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219 05 0446</u>		17. INFORMANT <u>ST AGNES HOSP RECORDS-BALTO MD 21229</u>	
18. <u>162.1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Terminal Ca of lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Terminal Ca of lung</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JUNE 12</u> <u>1970</u> to <u>JULY 3</u> <u>1970</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>JULY 3</u> <u>1970</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (XXXX) view the body after death.					
23A. SIGNATURE <u>Ching-Hui Tsai, M.D.</u>		23B. DATE SIGNED <u>07/04/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Ching-Hui Tsai, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
24D. LOCATION <u>Woodlawn, Maryland</u>		24E. STATE <u>21207</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1970</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Av., Catonsville, Md.</u>		25D. ADDRESS	

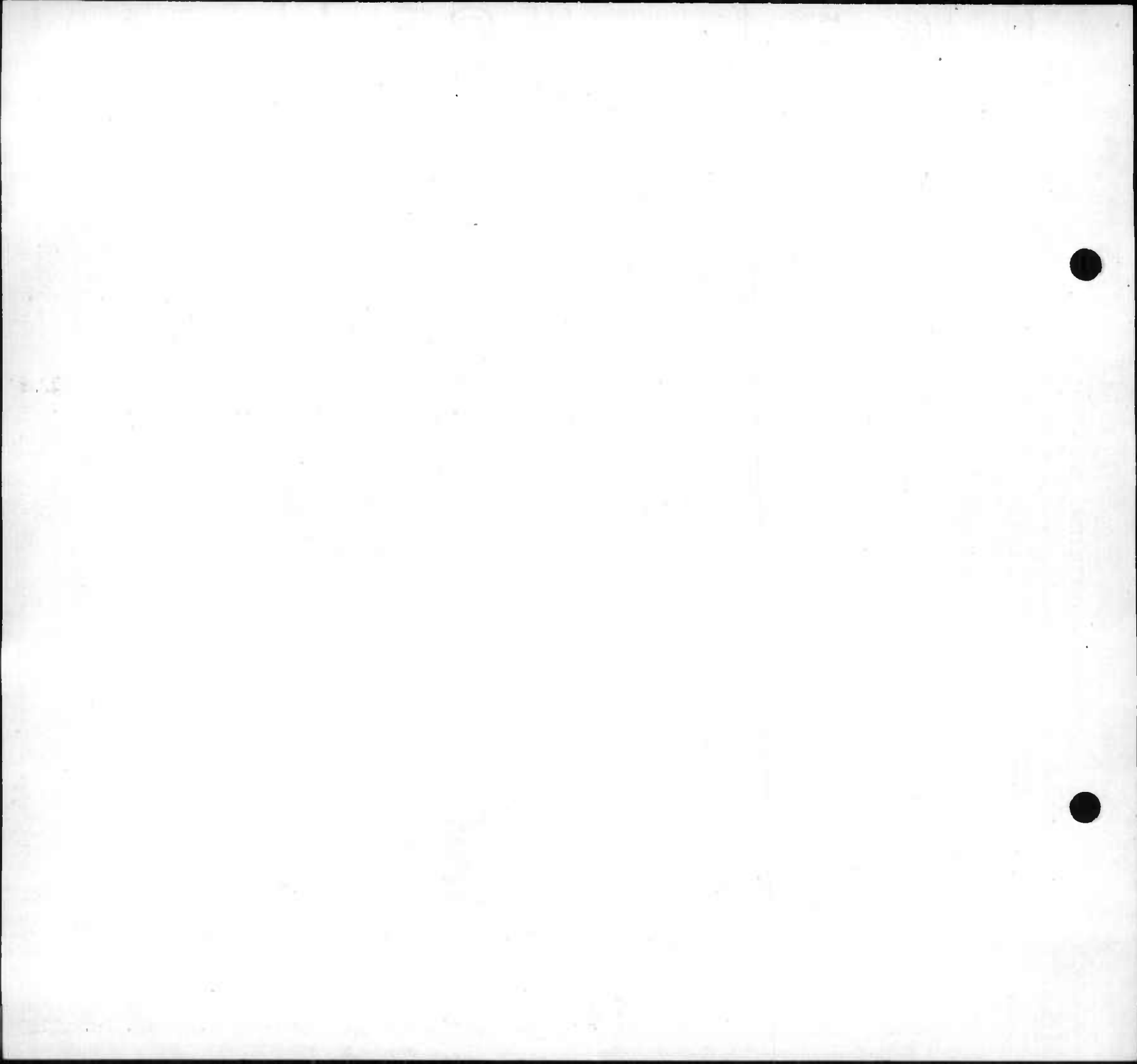
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 6783	
1. NAME OF DECEASED (Type or Print) Vincent Palacorolla				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 7 5 70 4:00 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 7 5 70 4:00 p.m.			
6. SEX male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Jan. 4, 1924				10. AGE (In years lost birthday) 46		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Late Joseph Palacorolla		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed	
15. MOTHER'S MAIDEN NAME Mary Trombero				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 6/10/43 - 1/29/46		17. SOCIAL SECURITY NO. 214-18-6910	
18. INFORMANT Mrs. Dolores Palacorolla				19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7/10/70				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/6/70							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/70		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore (Randallstown), Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Witzke		ADDRESS 101 Edmondson Av., Balto., Md. 21229	



FUNERAL DIRECTOR: IMPORTANT

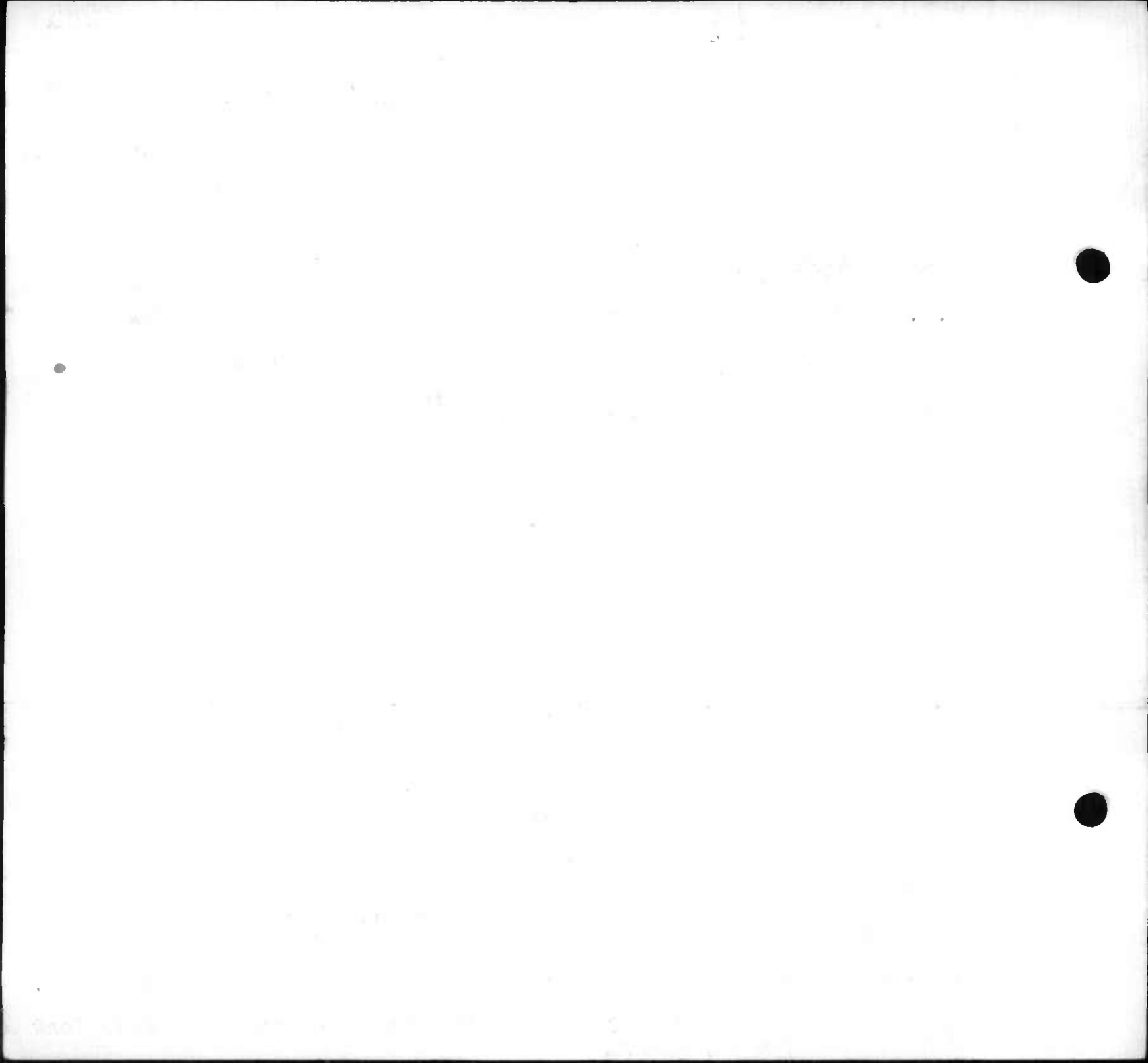
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. W-53270 6784		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6784	
1. NAME OF DECEASED (Type or Print) Windisch John (Windisch)		2. DATE AND HOUR OF DEATH 7-4-70 16:47 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital 730 Ashburton Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. 8. COUNTY 2037 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 126 Allendale ST			
5. SEX Male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-85	9. AGE (In years last birthday) 85	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. 216-10-7831		17. INFORMANT Mr. Clarence Wolf, 126 Allendale St., Balto. Md		ADDRESS 21229	
18. 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 10 1970 to July 4 1970 , that (I) (we) last saw the deceased alive on July 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Violeta R Gamarra R		23B. DATE SIGNED 7-4-70		23C. PHYSICIAN'S NAME (Type) VIOLETA R GAMARRA R. M.D.	
23D. ADDRESS 730 Ashburton St Baltimore Maryland		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/7/70		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. J. J. J.		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Av., Balto., Md. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-452		BALTIMORE CITY HEALTH DEPARTMENT		70 6785		REG. NO. _____	
1. NAME OF DECEASED (Type or Print) MR. CARL F. SCHLEUNES, SR.				2. DATE AND HOUR OF DEATH 7/1/70 1:35			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND 21231				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2743			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4608 WALTHER BLVD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/4/1901	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) V.P. RETIRED		10B. KIND OF BUSINESS OR INDUSTRY PRINTING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY SCHLEUNES				14. MOTHER'S MAIDEN NAME JULIA ? GANGER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 01 2508		17. INFORMANT JUSTINE F. SCHLEUNES		ADDRESS 4608 WALTHER BLVD.	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular accident. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 10 yrs.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 6/30/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/30 1970 to 7/1 1970 that (I) (we) last saw the deceased alive on 7/1 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A.E. Chouvalit, M.D.				23B. DATE SIGNED 7/1/70		23C. PHYSICIAN'S NAME (Type) A.E. CHOUVALIT, M.D.	
23D. ADDRESS CHURCH HOME & HOSPITAL BALTIMORE, MARYLAND 21231							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/6/70		24C. NAME OF CEMETERY OR CREMATORY LORRAINE CEMETERY		24D. LOCATION (City, town, or county) (State) WOODLAWN MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR MITCHELL WIEDEFELD HOME		ADDRESS 6500 YORK RD	



W-25270

6786

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

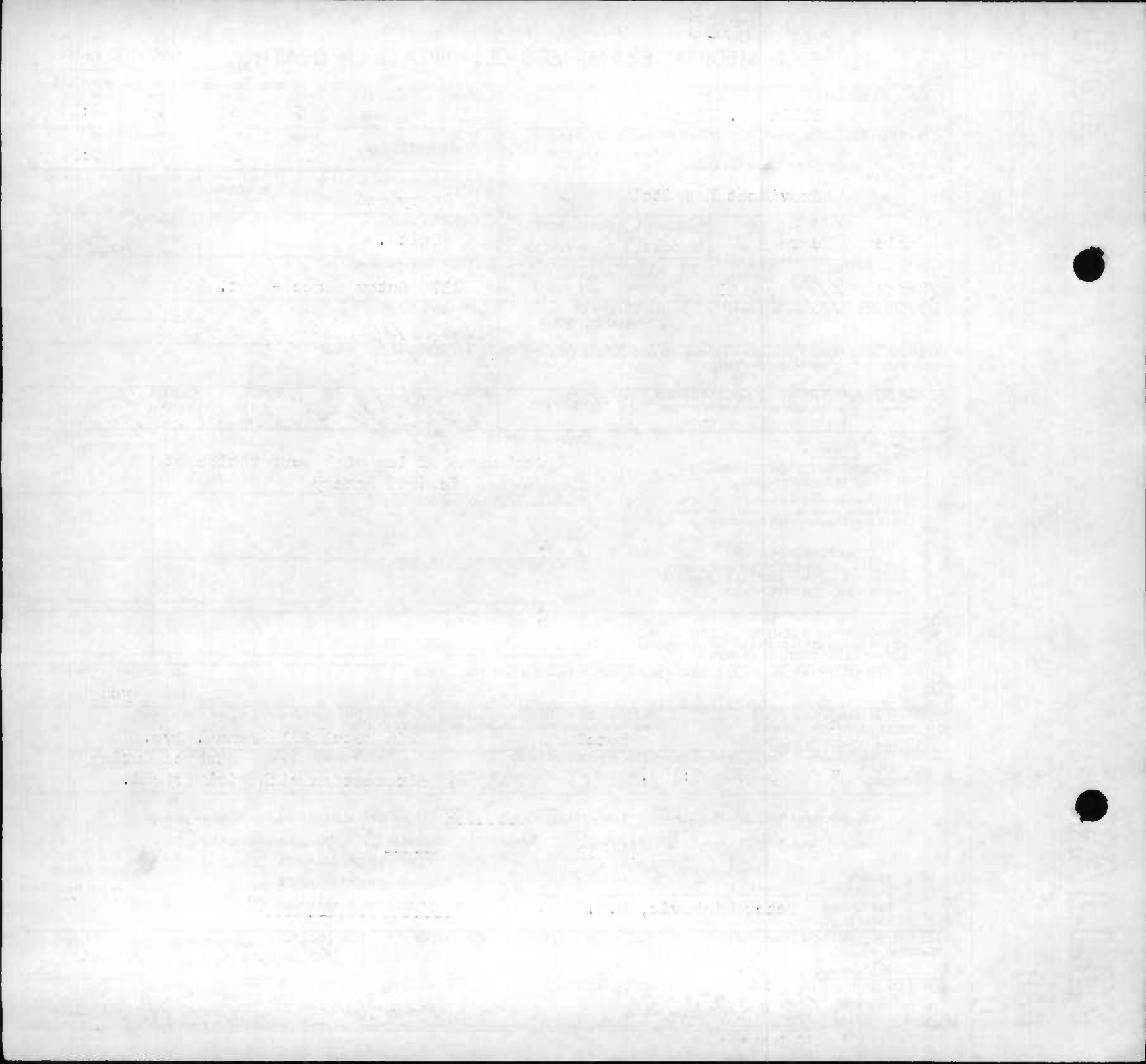
70

6786

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William P. Wiggins		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 5 70 Hour 9:30 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year 7 5 70 Hour 9:30 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1303	
9. DATE OF BIRTH 9-3-47		10. AGE (In years lost birthday) 23 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Nashley L. Brown		ADDRESS 2325 Bondville Street	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Stabwound of leg with perforation of femoral artery (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) hotel	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rio Hotel 1516 Penna. Ave.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7 5 70 9:19 p.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed during altercation with girl friend.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-7-70	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Jaber, Md	
25C. FUNERAL DIRECTOR W. W. W. W.		25D. ADDRESS 1632 W. North Ave	



R-300 70 6787

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6787

BIRTH NO.

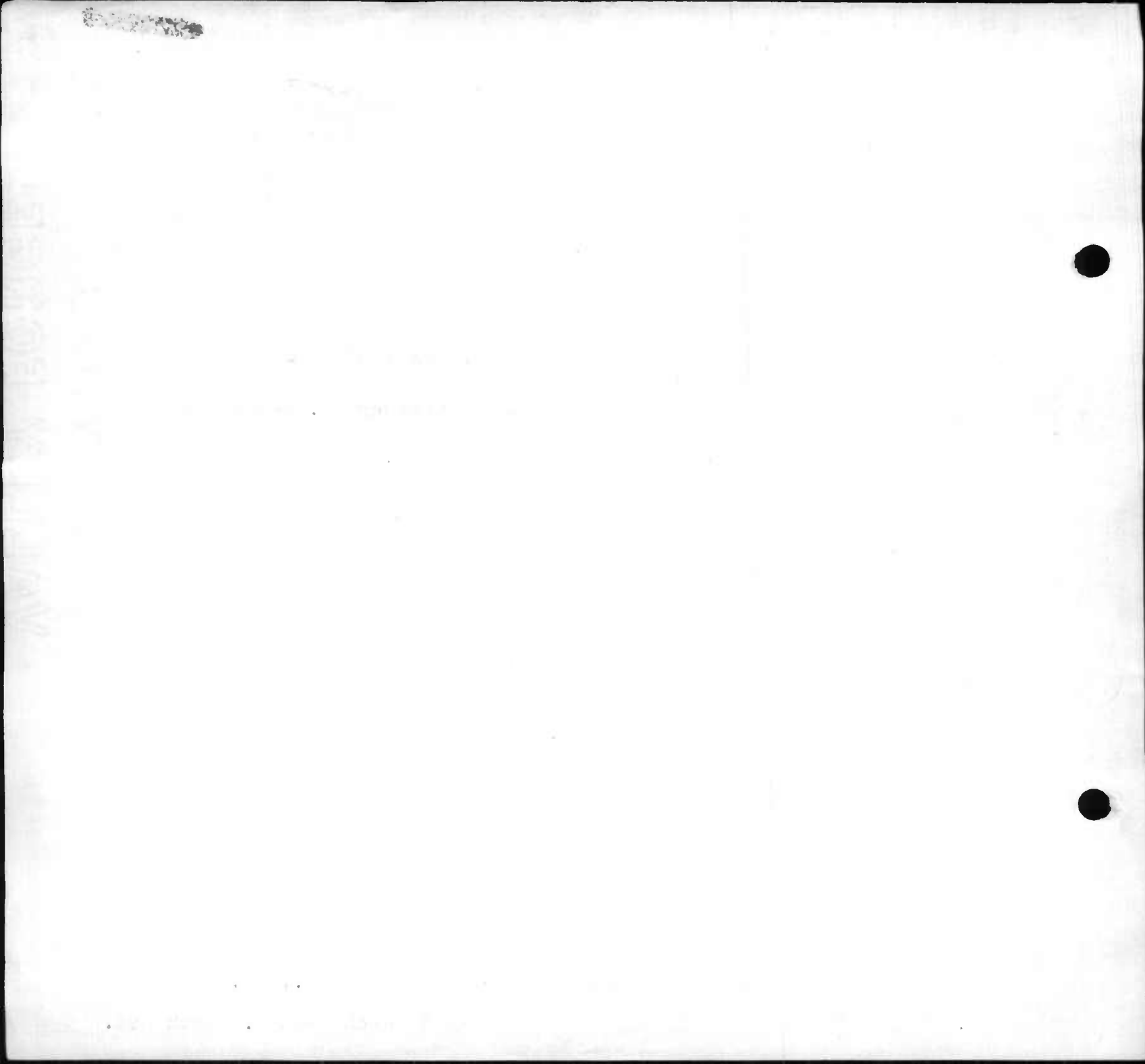
1. NAME OF DECEASED (Type or Print) Charles R. Redd				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 5 70 11:50 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital				3. DATE PRONOUNCED DEAD Month Day Year 7 5 70 11:50 P.M.			
6. SEX male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 906	
9. DATE OF BIRTH 3/7/42		10. AGE (In years last birthday) 26		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Cornelur Redd		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Viola		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Juanita Redd		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Gunshot wounds of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		20. DATE OF OPERATION 2	
21. AUTOPSY? (Yes or No) yes		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1800 Bl. Webb St.		24. HOW DID INJURY OCCUR? Shot by unknown assailant.	
25. TIME OF INJURY (APPROX.) 7 5 70 9:51p.		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		27. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		28. ACTUAL SIGNATURE Peter Lipkovic, M.D.	
29. DATE REC'D BY HEALTH DEPT. JUL 7 1970		30. NAME OF REGISTRAR Robert E. Taylor, M.D.		31. FUNERAL DIRECTOR Wm C March		32. ADDRESS 928 E. North Ave.	
33. BURIAL CREMATION, REMOVAL (Specify) Burial		34. DATE 7/10/70		35. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery		36. LOCATION (City, town, or county) (State) Anne Arundel Cty., Md.	

22c. NO 1800 block of Webb St.
called M. L. - no help.
Coded to Webb St 1200-1499.

FUNERAL DIRECTOR: IMPORTANT

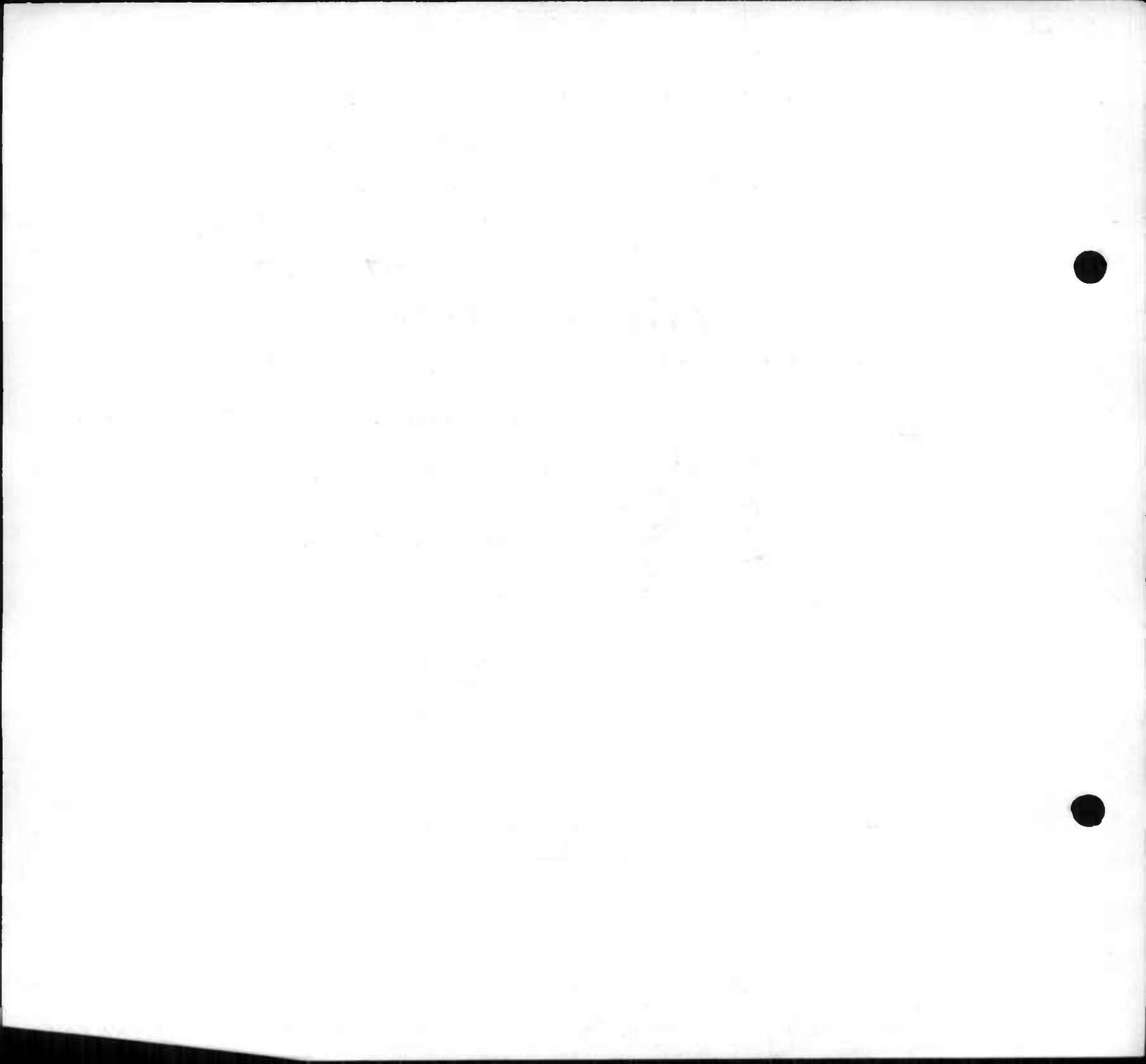
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>250</u> <u>70</u> <u>6788</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>70</u> <u>6788</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>REV. THEODORE C. JACKSON SR.</u>		2. DATE AND HOUR OF DEATH <u>JULY 3, 1970</u> <u>11:40 PM</u> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSPITAL</u>		A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> <u>1513</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>4014 Park Heights Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>E</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u>	8. DATE OF BIRTH <u>9/5/06</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Church</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Perry Jackson</u>		14. MOTHER'S MAIDEN NAME <u>SARAH MOTON</u>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Rev Theodore C. Jackson Jr</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>412.1 I</u> <u>CONGESTIVE HEART FAILURE</u> <u>CORONARY</u> <u>HYPERTENSION</u> <u>ANTHROSCLEROSIS</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>7</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 20</u> 19 <u>70</u> to <u>July - 3</u> 19 <u>70</u> . that (I) (we) last saw the deceased alive on <u>July 3</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>B. Maniquella</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7/4/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Saunders</u>		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/9/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Wm C March</u>	
				ADDRESS <u>928 E. North Ave.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

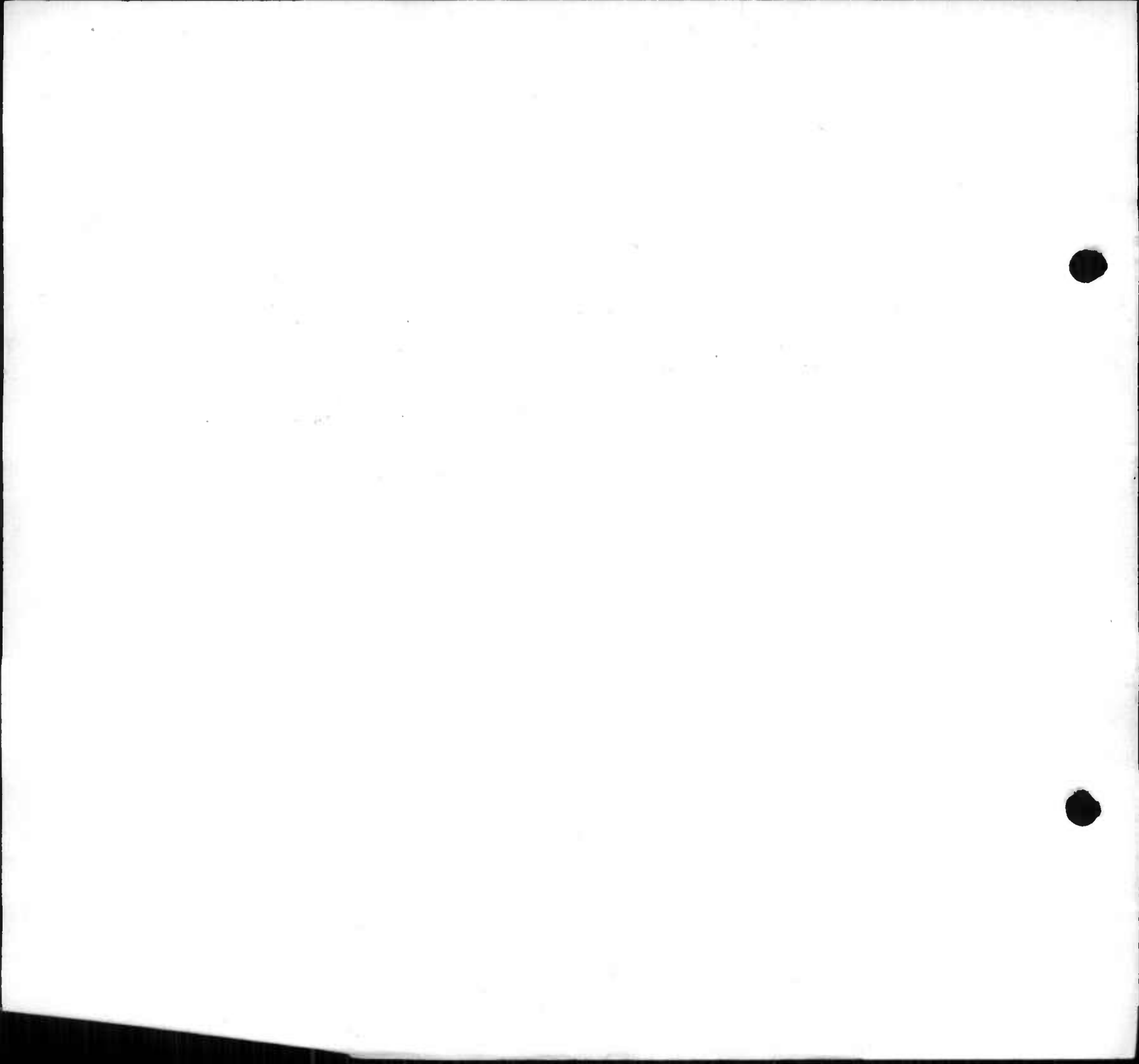
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
70 6789		CERTIFICATE OF DEATH		70 6789	
1. NAME OF DECEASED (Type or Print)		GRACE ALICE E.		2. DATE AND HOUR OF DEATH 7/6/70 11:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE		5300	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO CO.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
THE JOHNS HOPKINS HOSPITAL 33		E. STREET AND NUMBER 125 WILLOW SPRING RD. 21222			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/07	9. AGE (In years last birthday) 63	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY PACKER TIFF DECOR CO		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOSEPH SWEDERSKI		14. MOTHER'S MAIDEN NAME HELEN KANORSKI	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-05-487		17. INFORMANT JOSEPH W. GRACE 125 WILLOW SPRING RD	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (B) MYASTHENIA GRAVIS DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (this hospital) attended the deceased from SEPT 1966 to JULY 6 1970 that (I) lost saw the deceased alive on JULY 6 1970 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (saw) view the body after death.			
23A. SIGNATURE John W. Magladery M.D.		23B. DATE SIGNED 7/6/70		23C. PHYSICIAN'S NAME (Type) JOHN W. MAGLADERY	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/70	
24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		24D. LOCATION (City, town, or county) (State) GERMAN HILL RD BALTO MD		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970	
25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR THE DIPPEL BROS INC 1800 F		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		MAGGIE GIVINS (Givings)		2. DATE AND HOUR OF DEATH JUL. 6, 1970 12:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
LUTHERAN HOSPITAL OF MARYLAND 730 ASHBURTON STREET BALTIMORE, MARYLAND 21216			md. 1506 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			1625 Poplar Grove ST 21217		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
F	negro		5-18-11	54 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Home		Stoney Creek, Virginia	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Percy Frank Sykes			usa		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
NO			216-16-1979		cher (Mr. John Givins)
18. CAUSE OF DEATH			ADDRESS		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			CARDIAC ARREST		
(B) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from JULY 5, 1970 to JULY 6, 1970 that (I) (we) last saw the deceased alive on JULY 6, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Christos Dibravos M.D.			7. 6. 70		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
CHRISTOS DIBRAVOS, M.D.			730 ASHBURTON STREET BALTIMORE, MARYLAND 21216		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	7/10/70	Arbutus Mem. Park		Baltimore	
25A. DATE RECD BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JUL 7 1970		Robert E. Farber, M.D.		Morton E. Dyett, Jr.	



1
6-435

70 6791

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6791

BIRTH NO.		1. NAME OF DECEASED (Type or Print) S. SAMUEL GLADDEN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year 7 4 1970		Hour 8:14 P.M.	
6. SEX Male		7. RACE Negro		8. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1512	
9. DATE OF BIRTH 11-23-34		10. AGE (In years last birthday) 35		C. CITY OR TOWN Balto.	
11. BIRTHPLACE (State or foreign country) Durham, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13. FATHER'S NAME James Gladden		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		E. STREET AND NUMBER 2911 Keyworth Ave.	
15. MOTHER'S MAIDEN NAME Maude McKenney		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO.	
18. INFORMANT Mrs. Willie Royster		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 304.91 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		ADDRESS 2911 Keyworth Avenue	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 7-5-70 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-70		24C. NAME of CEMETERY or CREMATORY Baltimore Nat'l Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOMES, INC.		ADDRESS 1701 Laurens Street			

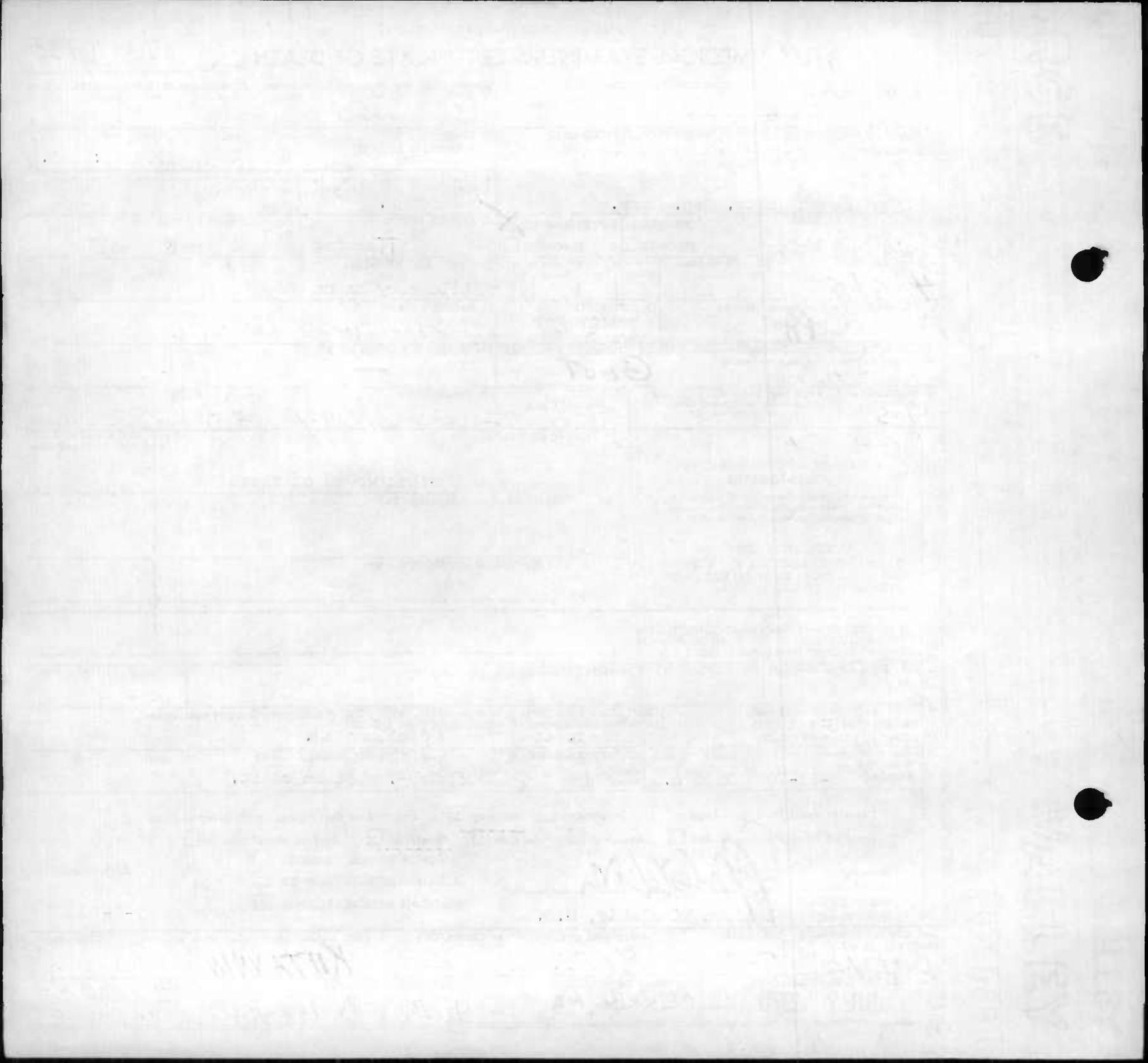
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ROBERT STUBBS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 73 South Balto. Gen. Hosp.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 4 1970 3:10 A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Kittanning	
9. DATE OF BIRTH 4/3/50		10. AGE (In years lost birthday) 20	
11. BIRTHPLACE (State or foreign country) PA		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Army		15. MOTHER'S MAIDEN NAME —	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 526-74-0402	
18. INFORMANT U.S. Army		ADDRESS Ft. Meade Md.	
19. CAUSE OF DEATH E965 X1		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22D. TIME OF INJURY (APPROX.) Month (Day) (Year) (Hour) 6-11-70 2:55 A. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Spellman Rd.		22F. HOW DID INJURY OCCUR? Subj. shot in chest.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		DATE SIGNED 7-4-70	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-7-70	
24C. NAME OF CEMETERY or CREMATORY KITTANNING		24D. LOCATION (City, town, or county) (State) KITTANNING Adams Township PA.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR ROBERT'S D'AMORICO		ADDRESS SEVERNA PARK, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 6793				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6793	
BIRTH NO.				BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Lola Toliver				2. DATE AND HOUR OF DEATH 6/30/1970 2:10 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 404 Allendale Street				A. STATE Maryland		B. COUNTY 2037	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 404 Allendale Street			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/1895	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Littleton, N. C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Howard				14. MOTHER'S MAIDEN NAME Ida Carter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Goldie Sykes		
					ADDRESS 404 Allendale St		
18. 410.9 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diabetes				(B) DUE TO, OR AS A CONSEQUENCE OF: unknown		(C) unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes						unknown	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/30 1965 to 6/30 1965 , and that (I) (we) last saw the deceased alive on 6/30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Donald W. Stewart				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/2/70	
23C. PHYSICIAN'S NAME (Type) Donald W. Stewart				23D. ADDRESS 2300 Garrison Blvd. (21216)			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/4/1970		24C. NAME OF CEMETERY or CREMATORY Oliver Grove Church Cem		24D. LOCATION (City, town, or county) (State) Littleton, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Nutter Funeral Home 3035 W. North Ave			

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N-425

BALTIMORE CITY HEALTH DEPARTMENT

70 6794

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6794

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FREDERICK E. NELSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 5 1970 1:35 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1702	
9. DATE OF BIRTH April 20, 1947		10. AGE (In years last birthday) 23	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Frederick Smith		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Mary D. Nelson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes	
17. SOCIAL SECURITY NO. 214-46-0541		18. INFORMANT Mary D. Nelson 442 Orchard Street	
19. E965X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes (head)		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 801 Druid Hill Ave. 1701	
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 7-5-70 1:30 A.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> (head)	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE July 8, 1970		24C. NAME of CEMETERY or CREMATORY Baltimore Nat Cem	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970	
25B. NAME OF REGISTRAR Isidore Mihalakis, M.D.		25C. FUNERAL DIRECTOR Nutter Funeral Home 3035 W. North Av	

Know all men by these presents, that J. B. NELSON, of the County of Dallas, State of Texas, for and in consideration of the sum of \$100.00, to him in hand paid by the undersigned, the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said J. B. NELSON, all that certain

Tract of Land, situate in the County of Dallas, State of Texas, containing

Acres, more or less, to have and to hold unto the said J. B. NELSON, his heirs and assigns forever.

And the said J. B. NELSON, his heirs and assigns, do hereby covenant, warrant and agree to defend the title hereunto in any and all courts of law and equity.

IN WITNESS WHEREOF, the said J. B. NELSON, has hereunto set his hand and seal of office, at the City of Dallas, State of Texas, this 1st day of January, 1911.

J. B. NELSON, Notary Public in and for the State of Texas.

My commission expires the 1st day of January, 1912.

Witness my hand and seal of office, at the City of Dallas, State of Texas, this 1st day of January, 1911.

J. B. NELSON, Notary Public in and for the State of Texas.

My commission expires the 1st day of January, 1912.

Witness my hand and seal of office, at the City of Dallas, State of Texas, this 1st day of January, 1911.

J. B. NELSON, Notary Public in and for the State of Texas.

My commission expires the 1st day of January, 1912.

Witness my hand and seal of office, at the City of Dallas, State of Texas, this 1st day of January, 1911.

ACADEMY BUILDING

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JAMES N. BROWN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour July 1, 1970 2:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour July 1, 1970 2:00 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300	
9. DATE OF BIRTH May 6, 1922		10. AGE (In years last birthday) 48	
11. BIRTHPLACE (State or foreign country) Elkridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Brown		14. MOTHER'S MAIDEN NAME Ida Green	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		16. KIND OF BUSINESS OR INDUSTRY Cemetery	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 7-1-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Baltimore National Cemetery	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 7-1-70 1:30 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Operating Tow Motor when vehicle turned over landing on subject.		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED July 2, 1970	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-70	
24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	

WALL, E. M. 1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BIRTH NO. H-323 70 6796		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6796	
1. NAME OF DECEASED (Type or Print) HATCHETT, ELIZACCH		2. DATE AND HOUR OF DEATH 7-2-70 3:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 909			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER HOUSE 10 THE PINES, BELVEDERE AVE			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-83	9. AGE (In years last birthday) 86	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME CHARLES CROXTON		14. MOTHER'S MAIDEN NAME HELEN A. LELAND			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-18-5643B		17. INFORMANT KATIE C. HARDING-2404 LONGWOOD ST.	
18. 514 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE pulmonary edema DUE TO, OR AS A CONSEQUENCE OF: (B) and acute congestion DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6-15-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6-15-70 to 7-2-70 that (1) (we) last saw the deceased alive on 7-1-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE J. P. Mikus M.D.		23B. DATE SIGNED 07-02-70		23C. PHYSICIAN'S NAME (Type) J. P. MIKUS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-6-70		24C. NAME of CEMETERY or CREMATORY Family Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Raben		25C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave.	
24D. LOCATION (City, town, or county) (State) Kenbridge, Virginia					

called N.H. Address was
1813 N. Aiken St. Admitted
5/15/90. Discharged 5/15/90
4

88 88

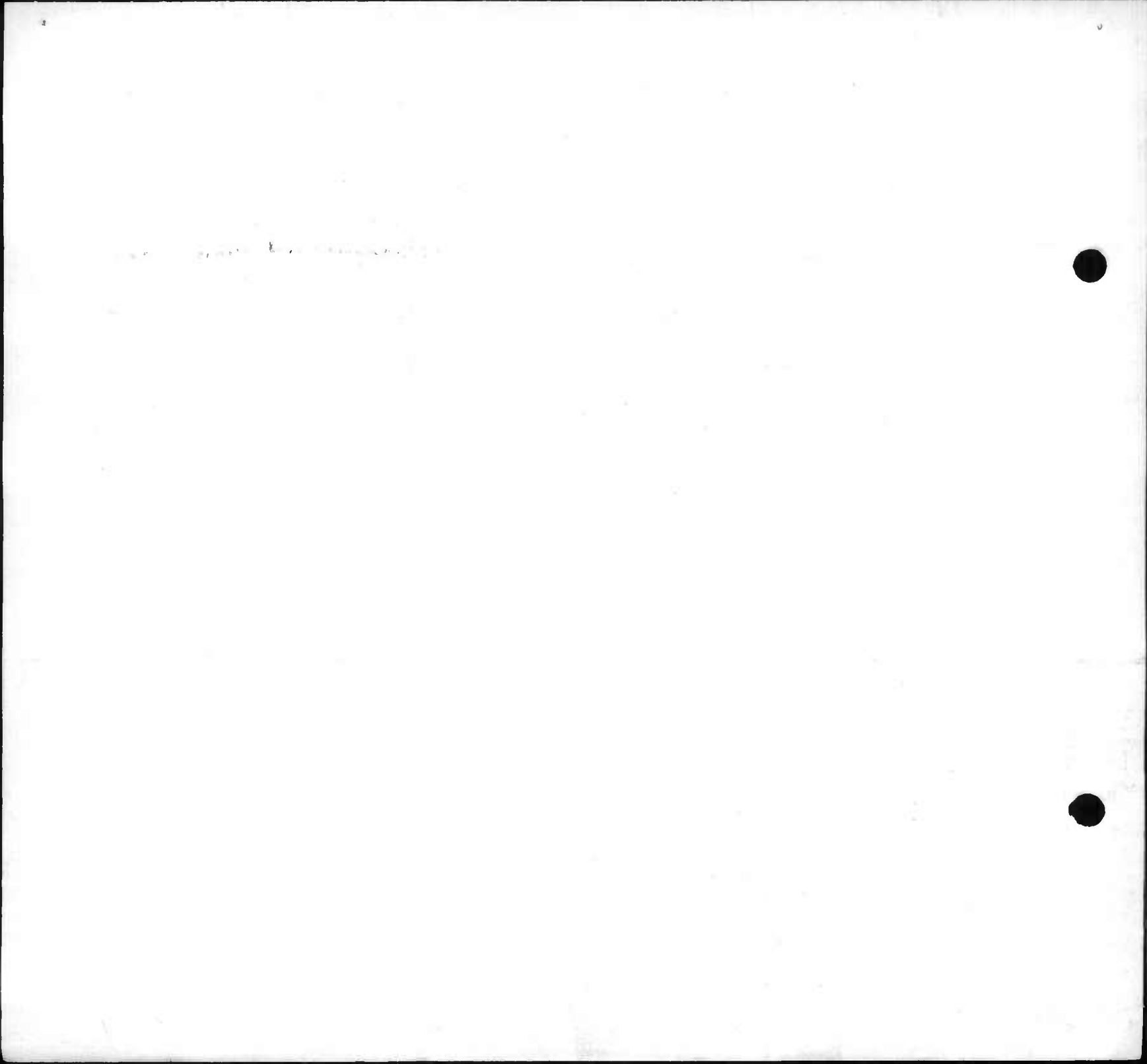
VIRGINIA

HORSE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6797	
CERTIFICATE OF DEATH					
T-250 70 6797 BIRTH NO. 1. NAME OF DECEASED <i>Bernard</i> (Type or Print) BERNARD TESNAU		2. DATE AND HOUR OF DEATH 7-3-70 10:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1803 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 824 HOLLINS ST.		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-1898	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabinet Maker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Restored Furniture</i>		11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>	
13. FATHER'S NAME <i>Friedrick Tesnau</i>			14. MOTHER'S MAIDEN NAME <i>Emilie</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. 36 7083		17. INFORMANT ADDRESS <i>Oswald Tesnau 25 S Linwood Ave 24</i>	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable MI ANTECEDENT CAUSES: DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Probable ASCVD			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable MI (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). MEDICAL CERTIFICATION					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-3-1970 to 7-3-1970 that (I) (we) last saw the deceased alive on 7-3-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Jaime F. Casellas</i>				23B. DATE SIGNED 7-3-70	
23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-70		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem	
24D. LOCATION Balto Md		24E. (City, town, or county)		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR Thomas J. Kenny Inc 1600 Hollins St	
25D. ADDRESS		25E. (City, town, or county)			



B-600

70 6798

BALTIMORE CITY HEALTH DEPARTMENT

70 6798

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

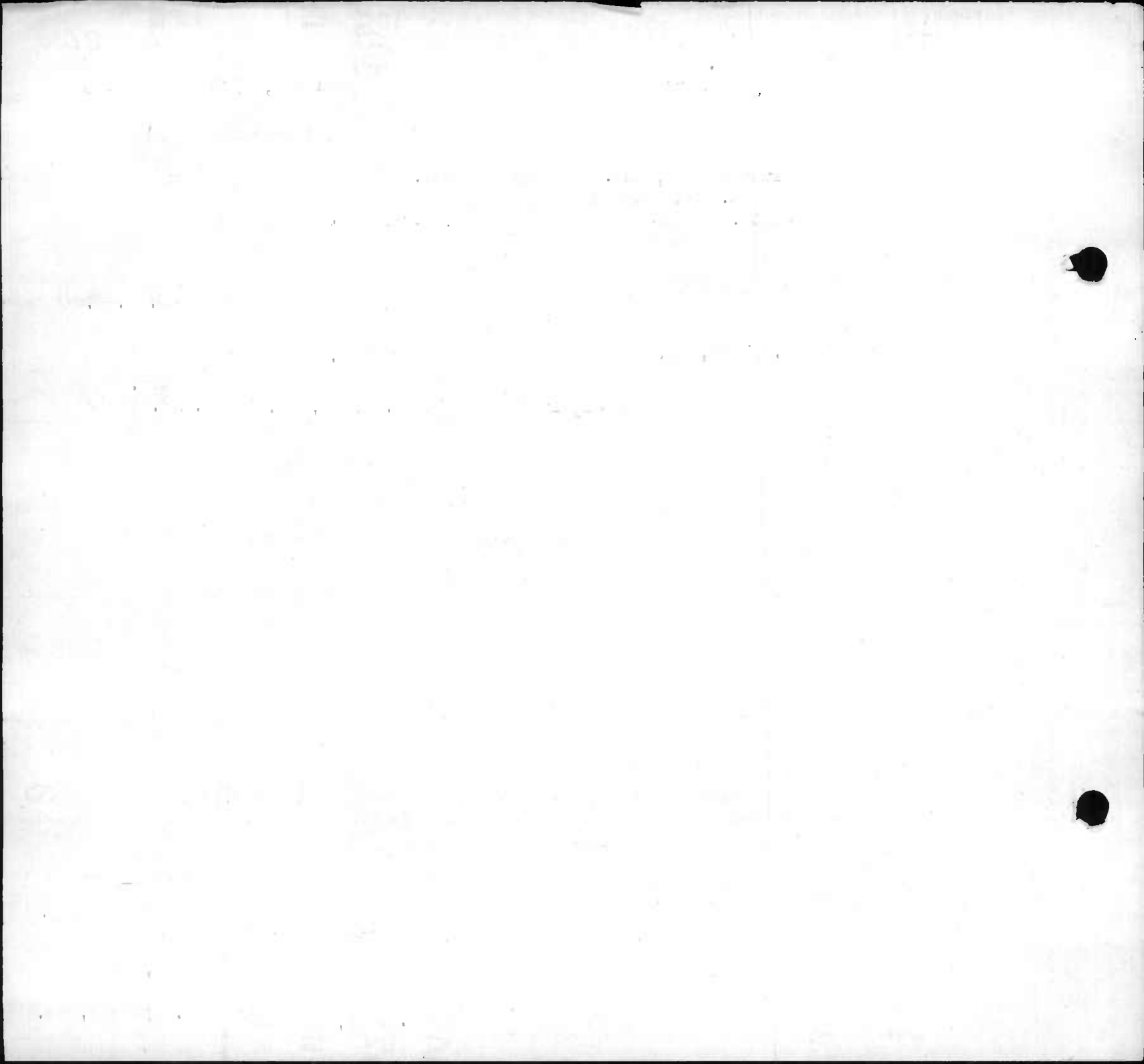
BIRTH NO.

1. NAME OF DECEASED (Type or Print) W. CLARENCE BERRY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1100 W. Pratt St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 3 1970 11:30 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 09/26/44		10. AGE (In years last birthday) 25	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Berry		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1903	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		14B. KIND OF BUSINESS OR INDUSTRY Contracting	
15. MOTHER'S MAIDEN NAME Viola Sullivan		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 216-42-9144		18. INFORMANT John H. Berry 205 So. Calhoun St.	
19. 304.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> 7-4-80			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 07/07/70	
24C. NAME OF CEMETERY or CREMATORY Crest Lawn Gardens		24D. LOCATION (City, town, or county) (State) Howard Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Walters Funeral Home		ADDRESS Pratt & Stricker Streets 21223	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

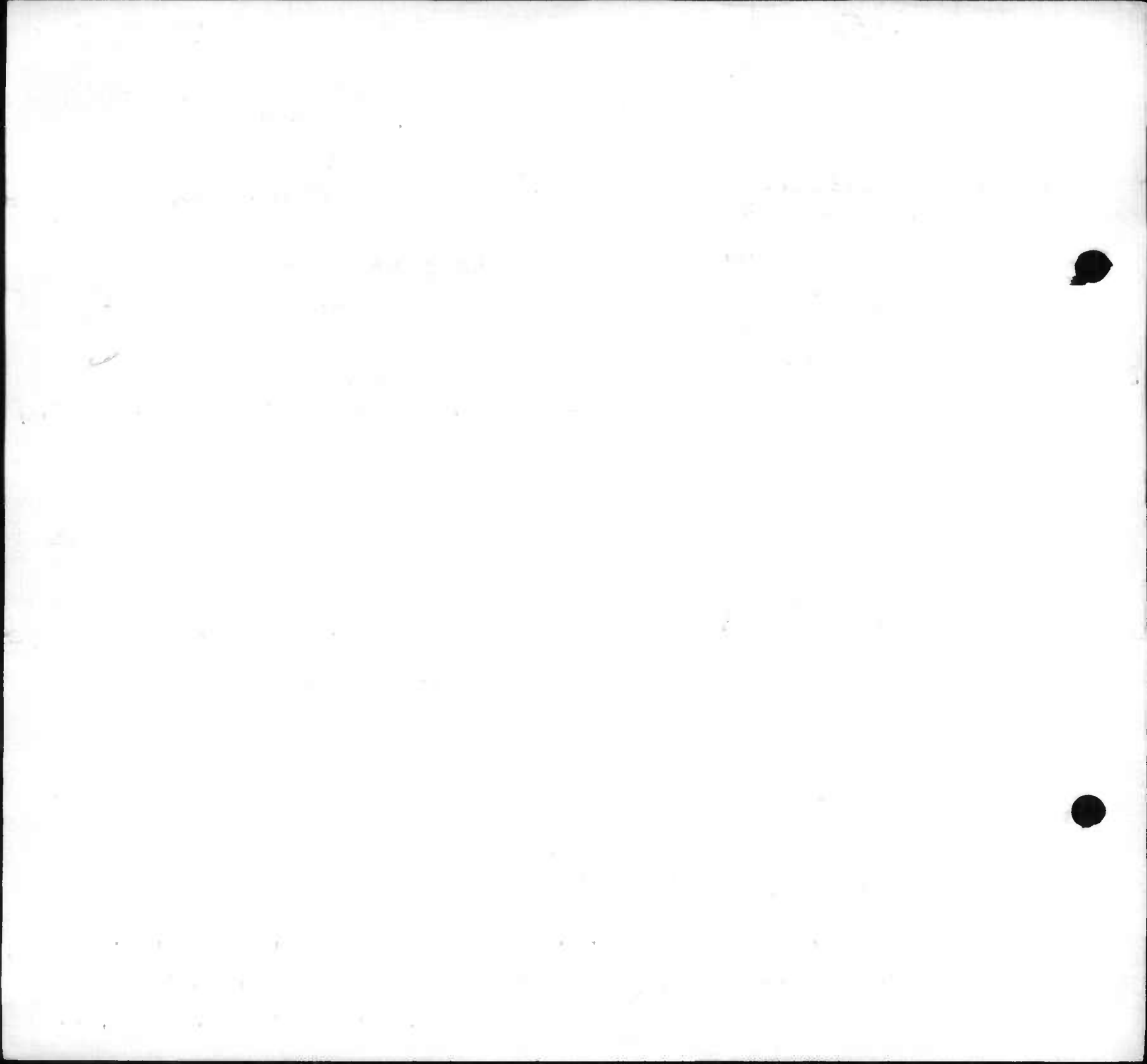
A-658		70 6799		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 6799	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) John Ahern				July 2, 1970 8:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Midtown Home, Inc. 808 St. Paul Street Balto. Md 21202				A. STATE Md B. COUNTY Baltimore			
C. CITY OR TOWN Edgemere				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 7312 Betz Ave. St							
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/91	9. AGE (In years last birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William J. Ahern, Sr.				14. MOTHER'S MAIDEN NAME Sarah J. Wrightson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 216-54-7122		17. INFORMANT (Brother) 7312 Betz Ave. William J. Ahern, Jr. Balto. Md. 21219		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio Respiratory Failure Cerebral Heart Failure (B) Antecedent Cause DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis CVA (C) Senile			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/15 1961 to 7/2 1970, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE William Applefeld				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED July 3-1970	
23C. PHYSICIAN'S NAME (Type) William Applefeld				23D. ADDRESS 706615 Newkirk St			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/70		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

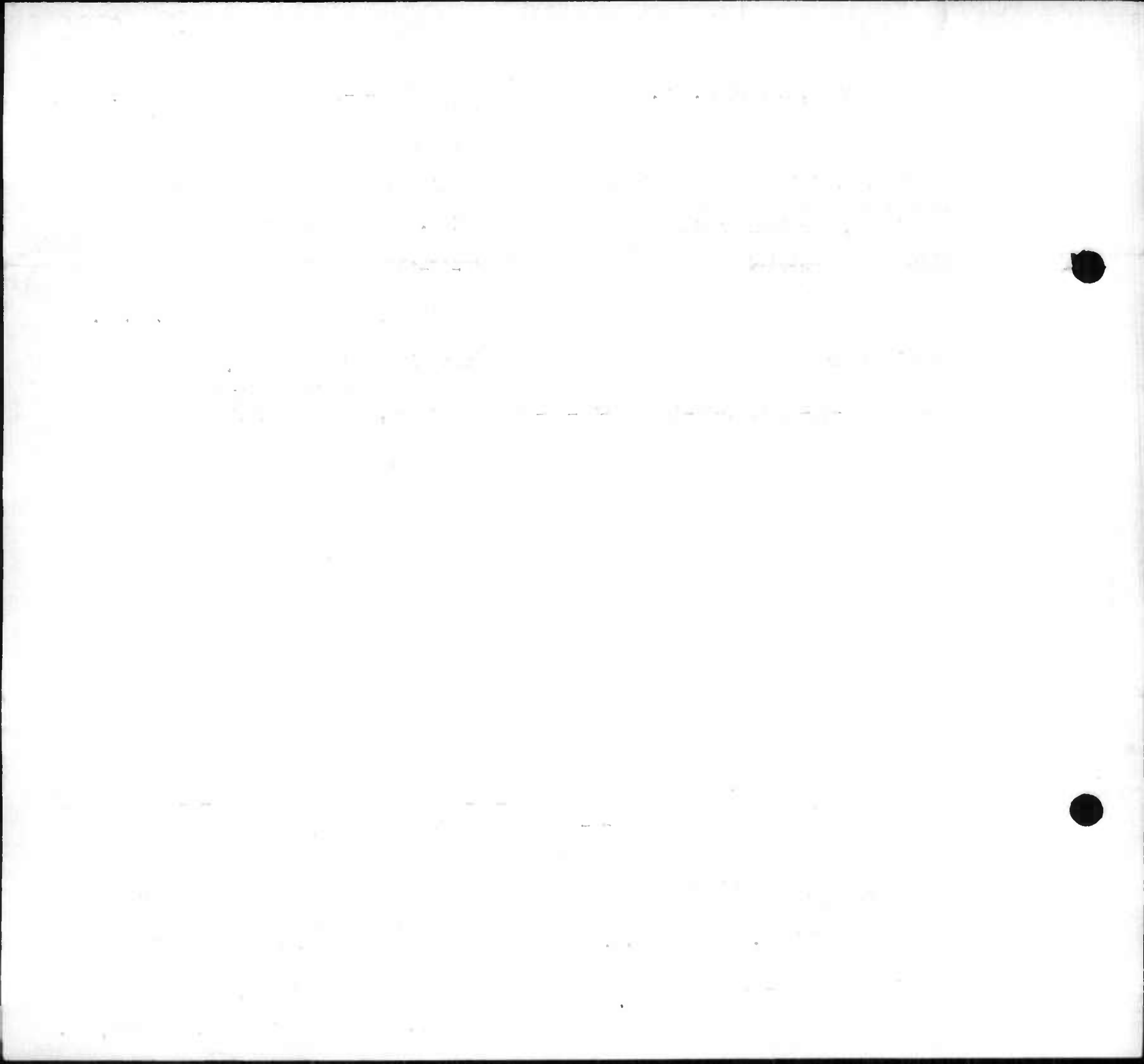
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-652 70 6800		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6800	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John F. Warns</u>		2. DATE AND HOUR OF DEATH <u>4 July 1970 1000/A M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u>		A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>2017 Holborn Road</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3/28</u>	9. AGE (In years last birthday) <u>42</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Wreck trucks</u>		11. BIRTHPLACE (State or foreign country) <u>USA Maryland</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>John Warns</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sichelstiel</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-24-8168</u>		17. INFORMANT <u>Wife</u> ADDRESS <u>Mrs. Doris Warns 2017 Holborn Rd. Dundalk, Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE <u>Resp. arrest</u> DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Brain tumor</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>4 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>27 Apr. 70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain tumor</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>4/24-7/4</u> to <u>7-4</u> 19 <u>70</u> that (we) last saw the deceased alive on <u>4 July</u> 19 <u>70</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David W. Cook MD</u>		23B. DATE SIGNED <u>4 July 70</u>			
23C. PHYSICIAN'S NAME (Type) <u>David W. Cook</u>		23D. ADDRESS <u>M. D. University Hospital, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-8-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1970</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR'S ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6801		REG. NO. 70 6801	
BIRTH NO. 5-340				70 6801		7-3-70	
1. NAME OF DECEASED (Type or Print) STYLE, Edward H. Sr.				2. DATE AND HOUR OF DEATH 7-3-70 7:55 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 601			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 201 N. Ellwood Avenue							
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-19	9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Ludwig Style				14. MOTHER'S MAIDEN NAME Josephine Dec			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5-14-43 to 1-15-46		16. SOCIAL SECURITY NO. 217-09-23-51		17. INFORMANT VA Hospital Records		ADDRESS Baltimore, Maryland 21218	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gastric Ulceration Cirrhosis of Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH week years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-22-19 70 to 7-3-19 70 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7-3-19 70 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE Ellis S. Caplan M.D.				23B. DATE SIGNED 7-5-70			
23C. PHYSICIAN'S NAME (Type) Ellis S. Caplan M.D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-70		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md.			

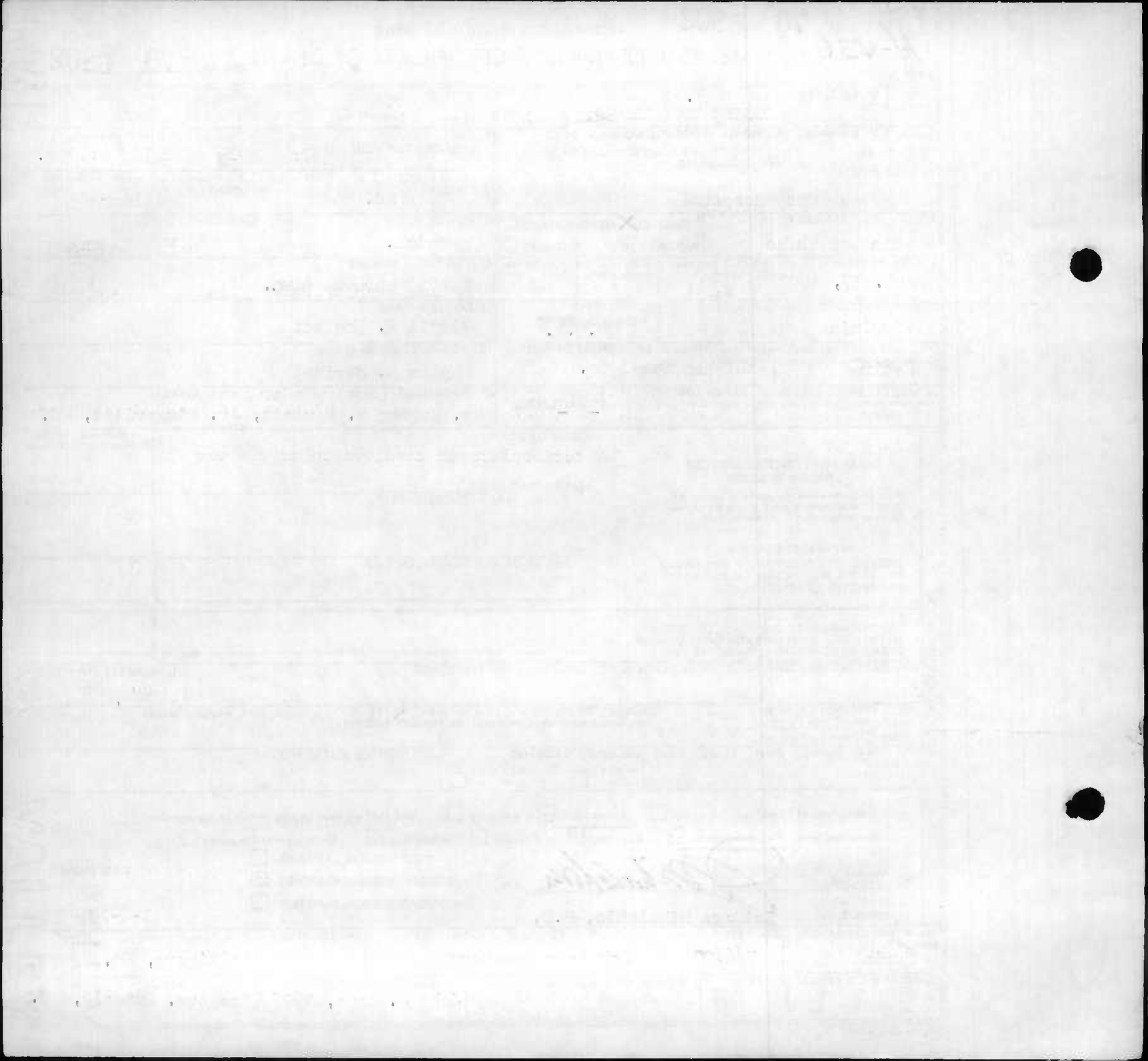


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6802

BIRTH NO.

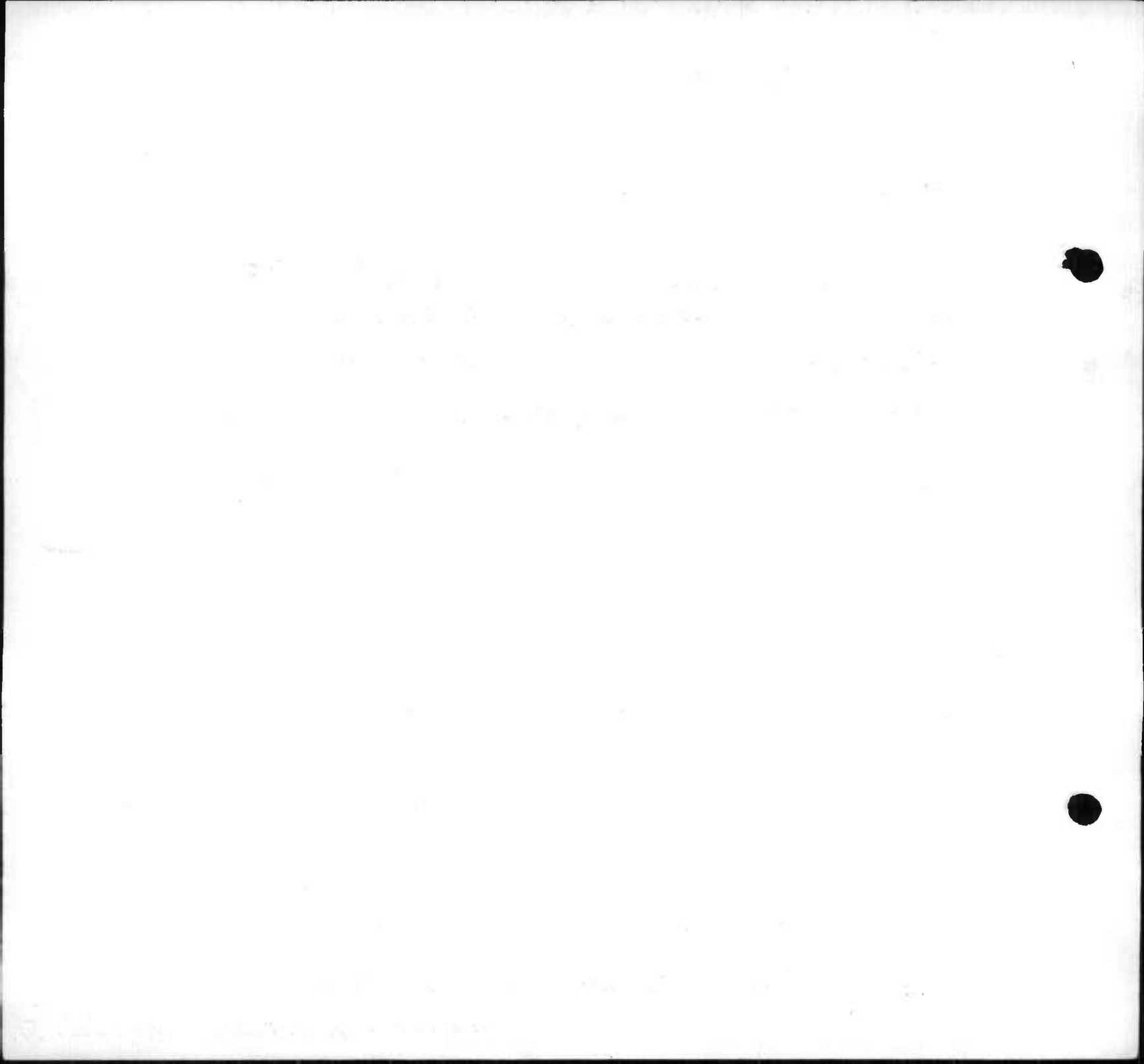
1. NAME OF DECEASED (Type or Print) F. EUGENE HOWLETT SR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 7n 3= 1970 4:40 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Dundalk	
9. DATE OF BIRTH Sept. 17, 1902		10. AGE (In years last birthday) 67	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Virgil R. Howlett		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
15. MOTHER'S MAIDEN NAME Martha E. Strigel		16. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	
17. SOCIAL SECURITY NO. 215-09-1671		18. INFORMANT (Son) Cedar Lane ADDRESS Mr. Eugene F. Howlett, Jr. Kingsville, Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-4-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/70	
24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Sauer	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6803</u>	
K-520 70 6803				CERTIFICATE OF DEATH	
BIRTH NO. <u>K-520</u>		70 6803			
1. NAME OF DECEASED (Type or Print) <u>(ANDREW) HENRY KANIECKI</u>			2. DATE AND HOUR OF DEATH <u>7/2/1970 10.20 PM.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Maryland Gen. Hospital.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore City.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>9055 Potomac St.</u>		
5. SEX <u>M</u>	6. RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/93</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARETAKER Ret.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CEMETERY</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>KONSTAN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-074376</u>	17. INFORMANT <u>Daughter wife MRS. MARTHA KANIECKI</u> ADDRESS <u>905 S. Potomac St.</u>		
18. <u>207.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Cardiac Arrest / Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Leukemia.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO.</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/2/1970</u> to <u>7/2/1970</u> that (I) (we) last saw the deceased alive on <u>7/2/1970</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M S al Ibrahim</u>			23B. DATE SIGNED <u>7/2/1970</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>AL-IBRAHIM MD</u>			23D. ADDRESS _____		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/6/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>ST. STANISLAUS Cem.</u>	
24D. LOCATION (City, town, or county) <u>BALTIMORE MD.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor MD.</u>		25C. FUNERAL DIRECTOR <u>RAYMOND L. KACZOROWSKI</u> ADDRESS <u>2525 FLEET ST.</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6804

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES, JACOBS JR.		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 7 Day 4 Year 70 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month 7 Day 4 Year 1970 Hour 3:15 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 6-17-47		10. AGE (In years last birthday) 23	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB JAMES		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 904	
15. MOTHER'S MAIDEN NAME BARBARA COBURN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES VIETNAM	
17. SOCIAL SECURITY NO. 29-42-278		18. INFORMANT MRS. BARBARA JAMES	
19. CAUSE OF DEATH E924X I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Burns of body & head, thermal & chemical		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) factory		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rockland Ind.	
22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) 7-1-70 12 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Was working & stumbled and fell in		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) PETER LIPKOVIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 7-5-70		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE 7/8/1970		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NAT'L	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR RAYMOND L. KACZOROWSKI	
ADDRESS 2525 FLEET ST.			

10801 10801 10801

1-17-47

MARKED U.S.A. JAMES BARBARA COBURN
YES VETERAN AND-ONE RING BARBARA JAMES THE 37

Bureau of Police Baltimore Md.
James A. K...
10801

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
8-530 70		6805		70 6805	
1. NAME OF DECEASED (Type or Print) ETHEEN SMITH				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 934 McDonough St.				3. DATE PRONOUNCED DEAD Month Day Year Hour 7 4 1970 1:05 P.M.	
6. SEX Male				5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 704	
7. RACE Negroid		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10-6-22		10. AGE (In years lost birthday) 48		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 934 McDonough St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Roseetta Watson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 239-28-5615		18. INFORMANT ADDRESS HERMAN SMITH 2004 BRADDISH	
19. CAUSE OF DEATH E880 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 934 McDonough St. 704				22F. HOW DID INJURY OCCUR? Fell down steps.	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-4-70 ? m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 7-5-70 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7-70		24C. NAME OF CEMETERY or CREMATORY CHURCH CEM.	
24D. LOCATION (City, town, or county) (State) SMITHFIELD, N.C.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS KEESON B.H. 1348 CALHOUN ST.			

NAME

DATE

COMPLIANT (10/1/16)

[Signature]

S-530

70 6806

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6806

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JEROME SMITH

2. DATE
OF DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

July

1, 1970

10:55 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

July

1, 1970

10:55 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1606

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7-19-33

10. AGE (In years last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3036 HARLEM AVE.

11. BIRTHPLACE (State or foreign country)

md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Driver

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Helen

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES 2-20-53-5-20-55

17. SOCIAL SECURITY NO.

113-40-1235

18. INFORMANT

ADDRESS

Josephine Bowler - 4311 Reisterstown

19.

E965X I

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of chest
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

sidewalk

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

1519 Riggs Avenue

22D. TIME (Month) (Day) (Year) (Hour) (Approx.)

7-1-70 10:40 P.M.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during altercation

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

July 2, 1970

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

7-6-70

24C. NAME OF CEMETERY or CREMATORY

LONDON PK. Nat'l.

24D. LOCATION (City, town, or county) (State)

BALTO. md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 7 1970

25B. NAME OF REGISTRAR

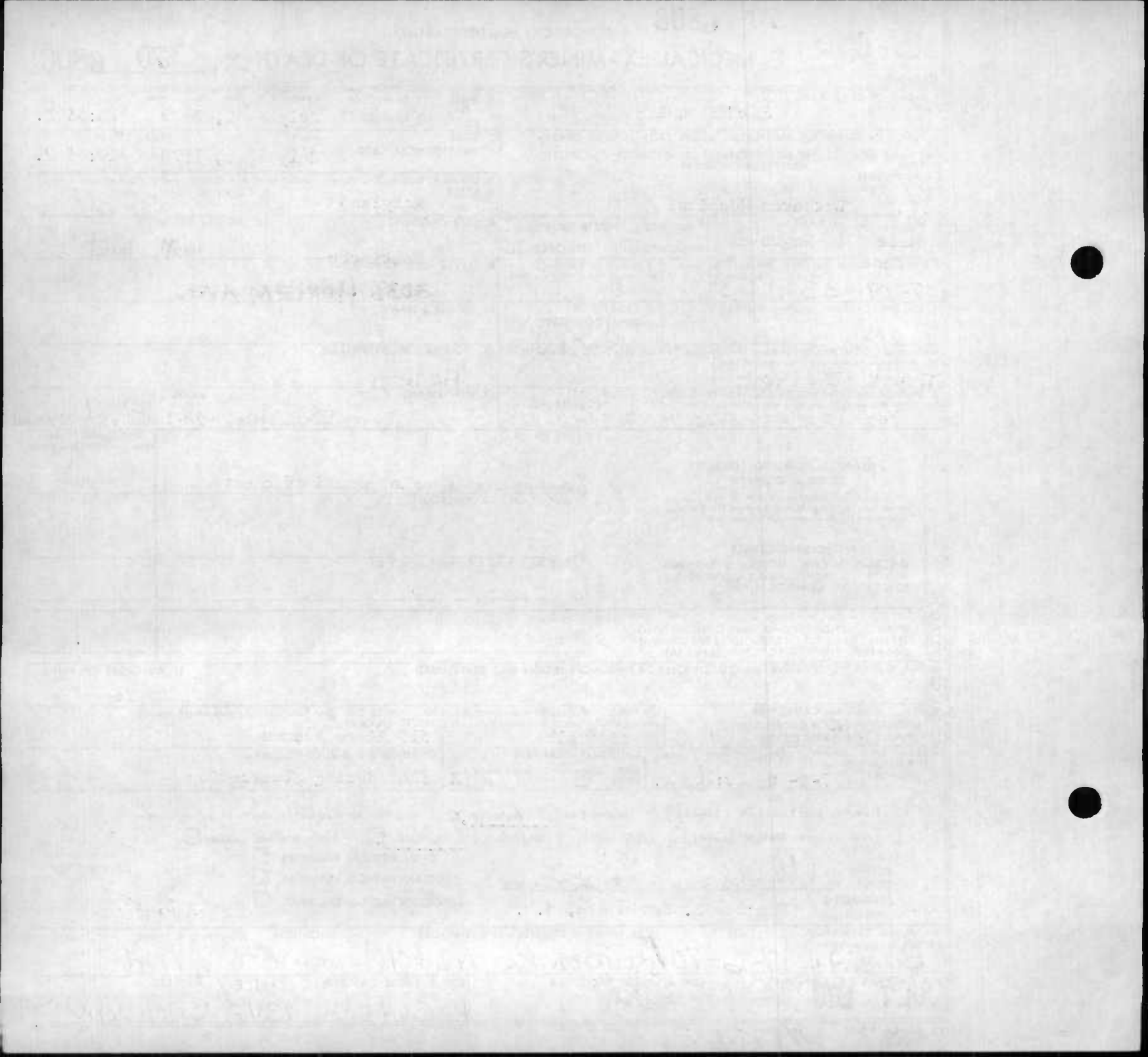
Charles E. Taylor, M.D.

25C. FUNERAL DIRECTOR

V. BAILEY

ADDRESS

BEVERLY H. 1348 CALHOUN ST.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6807

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JAMES DIXON

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

39 PROVIDENT HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

A.M.

7

4

1970

1:30

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☒NO ☐

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

9. DATE OF BIRTH

7-19-41

10. AGE (in years
last birthday)

28

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

E. STREET AND NUMBER

5107 Fembbridge Avenue

4675 Park Heights Ave.

13. FATHER'S NAME

John Dixon

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck driver

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Ollie Lee

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, never unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

217384345

18. INFORMANT

Helen Dixon

ADDRESS

same

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Stab wound of heart
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1600 blk. Westwood Ave. 1501

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

7-4-70

?

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subj. stabbed.

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7-4-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-7-70

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 7 1970

25B. NAME OF REGISTRAR

Robert E. Bailey, M.D.

25C. FUNERAL DIRECTOR

V. Bailey ADDRESS

Kelson F.M. 1348 Calhoun Street

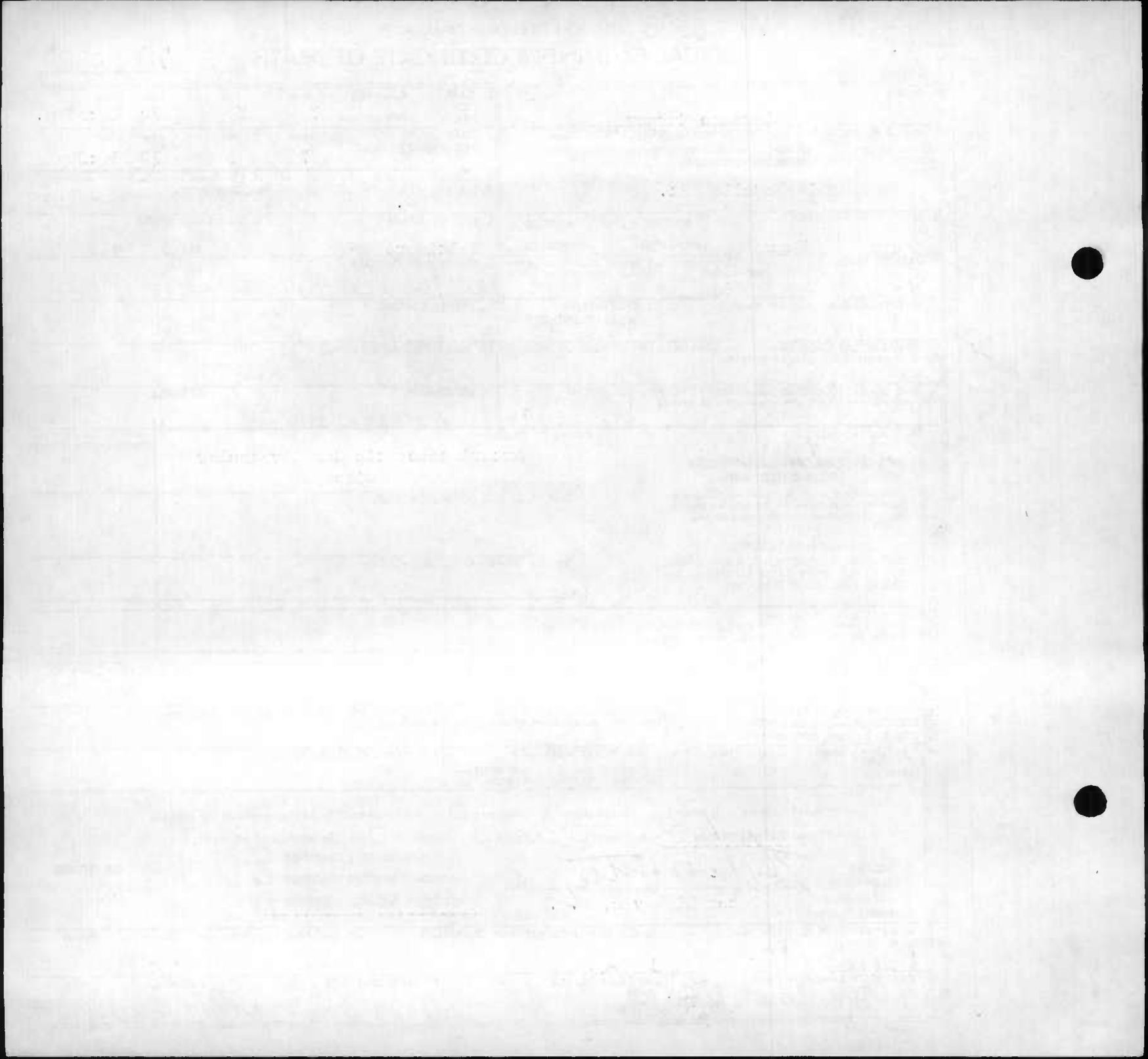
7/8/70 - Correction form from general director
L.F.O.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6808

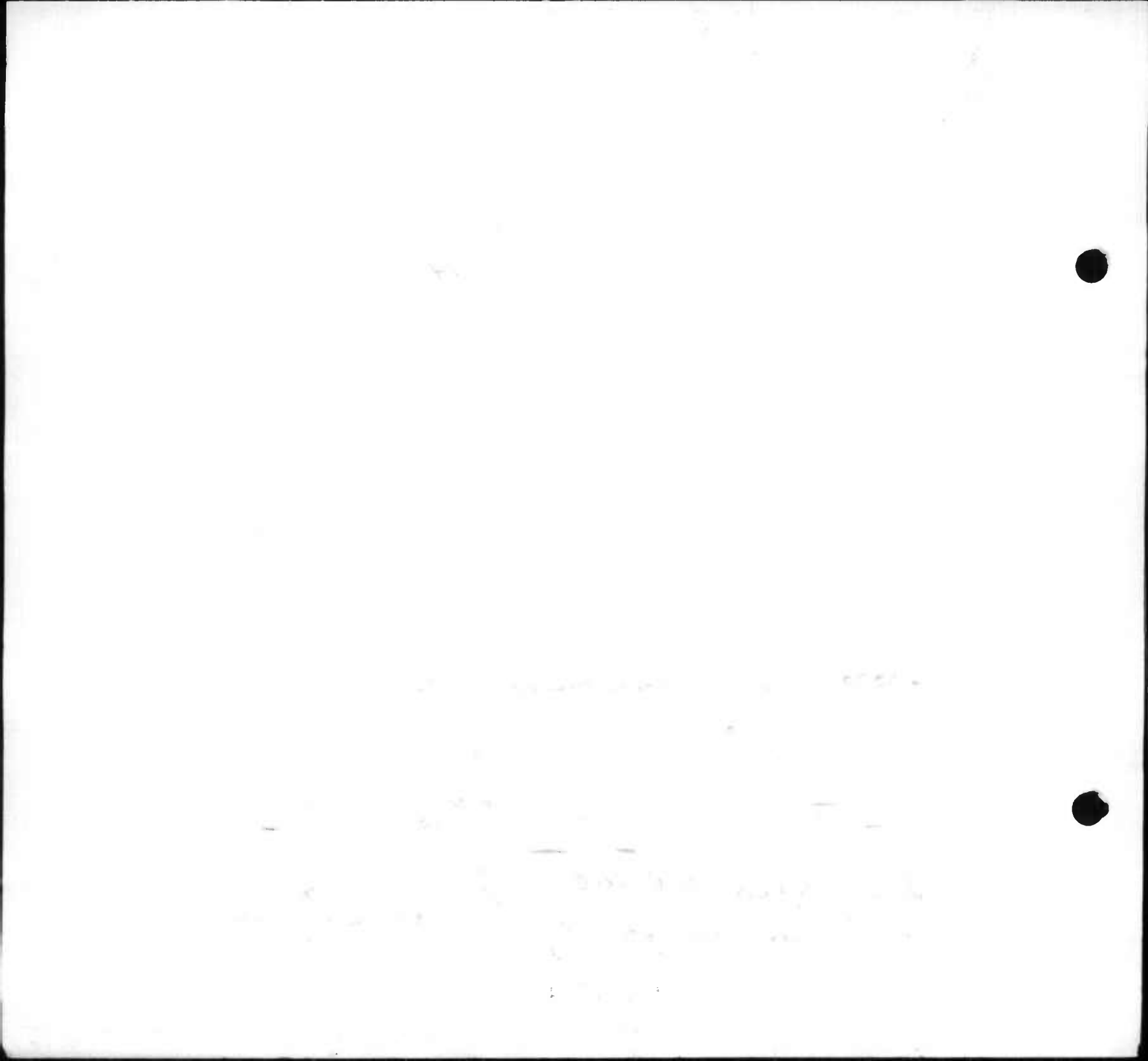
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clarence Turner		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 5 70 10:50 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2316 McCulloh St.		3. DATE PRONOUNCED DEAD Month Day Year 7 5 70 10:50p m.	
6. SEX male		7. RACE Negroid	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-30-01		10. AGE (in years last birthday) 68	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Turner		14. MOTHER'S MAIDEN NAME Emma Short	
15. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1303		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 015-09-1199	
18. INFORMANT Mammie Turner		ADDRESS SAME	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH NO	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7-9-70		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 7/6/70 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-70	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR WELSON F. H.		ADDRESS 1348 Calhoun St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6809		REG. NO. 70 6809	
BIRTH NO. J-520				70 6809		70 6809	
1. NAME OF DECEASED (Type or Print) <i>Reverend Willie Jones</i>				2. DATE AND HOUR OF DEATH <i>July 5, 1970</i> <i>5:10 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Bon Secour Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1901</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secour Hospital</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				E. STREET AND NUMBER <i>324 N. Mount Street</i>			
5. SEX <i>male</i>	6. RACE <i>Black</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/14/15</i>	9. AGE (In years last birthday) <i>55</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>minister</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Willie Jones</i>				14. MOTHER'S MAIDEN NAME <i>C. Paterson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>249-14-4940</i>		17. INFORMANT <i>Rosalie Jones</i>		ADDRESS <i>SAME</i>	
18. <i>204.1</i> I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Septicemia</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Femoral artery occlusion</i> <i>Chronic lymphocytic leukemia?</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>7-30-70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ACUTE FEMORAL OCCLUSION</i>		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <i>(1)</i> (this hospital) attended the deceased from <i>6:30</i> <i>1970</i> to <i>7:5</i> <i>1970</i> that <i>(1)</i> <i>(man)</i> last saw the deceased alive on <i>7:5</i> <i>1970</i> and that <i>(1)</i> <i>(man)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(1)</i> <i>(man)</i> (did) <i>(did not)</i> view the body after death.							
23A. SIGNATURE <i>Sam B. Kerr M.B. C.B.</i>				23B. DATE SIGNED <i>7-5-70</i>		23C. PHYSICIAN'S NAME (Type) <i>AIN C. KERR M.B. C.B.</i>	
23D. ADDRESS <i>BON SECOUR HOSP. 2025 W. FAYETTE ST #23</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-11-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Mem. Pk.</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 7 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor M.B.</i>		25C. FUNERAL DIRECTOR <i>U. BAILEY</i>		ADDRESS <i>KELSON F.H. 1348 BALHOUN ST.</i>	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 6810
 REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BERNICE MICKENS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 2, 1970	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1039 N. Durham Street		3. DATE PRONOUNCED DEAD Month Day Year July 2, 1970 Hour 3:55 A.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Sept. 30, 1926		10. AGE (In years last birthday) 43	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barmaid		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Isabel Penn's		18. INFORMANT Mrs. Davis Cousins	
19. 571.9 I		ADDRESS 4209 Ivanhoe Ave.	

MEDICAL CERTIFICATION	19. 571.9 I		CAUSE OF DEATH Massive gastrointestinal hemorrhage	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF:	
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	

20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Springate** M.D.
 EXAMINER'S NAME (Type) **Charles S. Springate, M.D.**

CHIEF MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **July 2, 1970**

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/8/70	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	24D. LOCATION (City, town, or county) (State) Westport Md.
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970	25B. NAME OF REGISTRAR John F. Taylor, M.D.	25C. FUNERAL DIRECTOR Milton E. Elchman	ADDRESS 1129 W. Camden

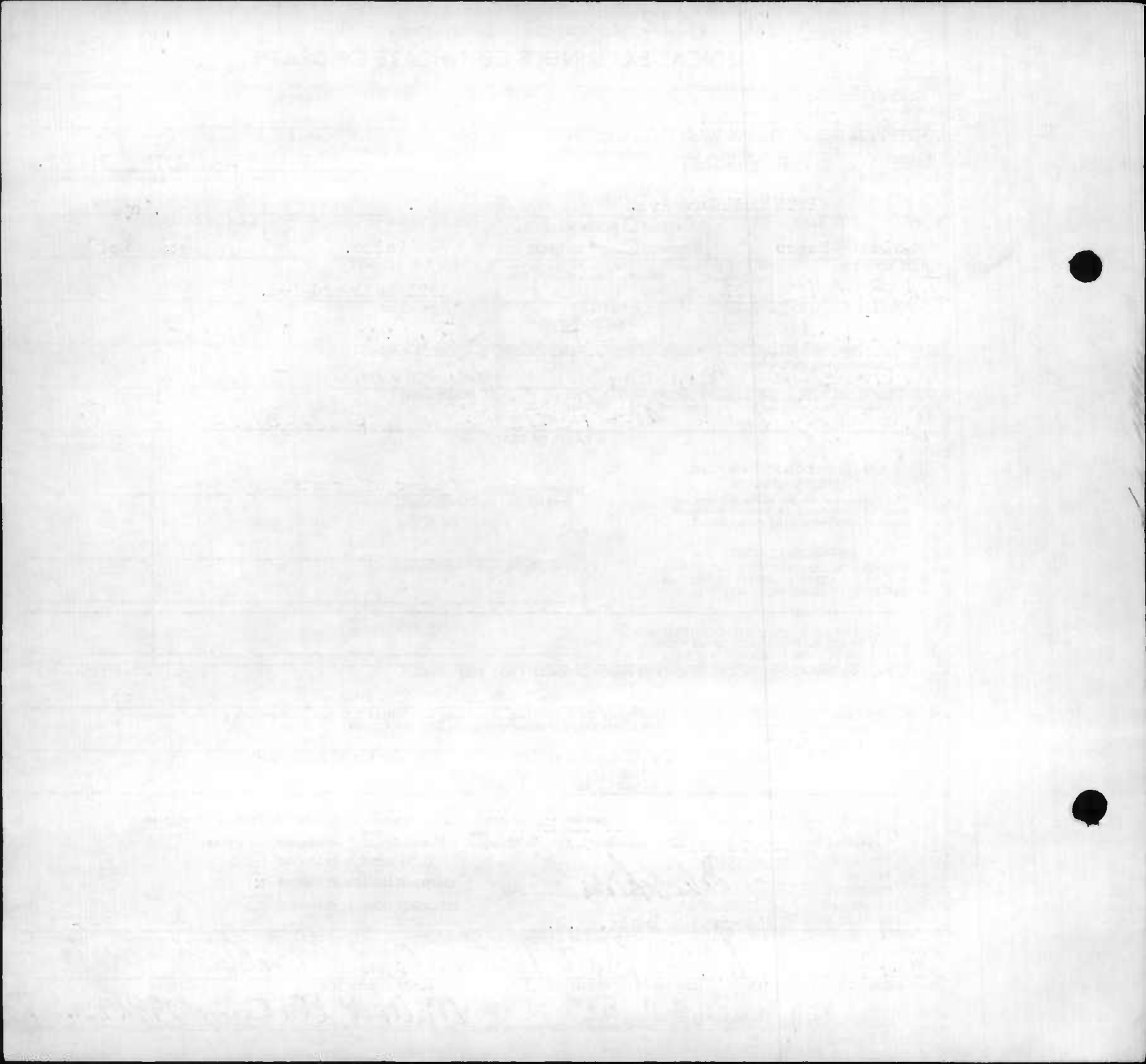
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-520 70 6811		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6811	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EDWARD THOMAS		2. DATE AND HOUR OF DEATH July 4, 1970 9:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY 909			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1505 LAMONT STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-08	9. AGE (In years last birthday) 61	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor - Retired.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Thomas		14. MOTHER'S MAIDEN NAME Minnie L. Stokes	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 229-129507		17. INFORMANT Mrs. Mary Dabney - Hollins Springs, Va.	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Disseminated Carcinoma of the Prostate DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7-1-1970 to 7-4-1970 that (I) (we) last saw the deceased alive on 7-4-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Joseph O. Moore		23B. DATE SIGNED 7/4/70			
23C. PHYSICIAN'S NAME (Type) Joseph O. Moore		23D. ADDRESS Johns Hopkins Hospital Baltimore Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/9/70		24C. NAME OF CEMETERY OR CREMATORY Drakes Branch Ct. Va.	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Tarber, M.D.	
25C. FUNERAL DIRECTOR Dorothy R. Lickson		25D. ADDRESS 1129 N. Caroline St			

70 6812 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 6812

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES SKINNER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1921 Guilford Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 3 1970 7:40 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1204	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Jul 3, 1893		10. AGE (In years lost birthday) 77	11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - A.A. Chemich		16. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Elizabeth Honner	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I.		17. SOCIAL SECURITY NO. 212-01-2673		18. INFORMANT ADDRESS Elenora Spence - 317 E. 23rd St.	
19. CAUSE OF DEATH 185X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-4-70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/70		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem	
24D. LOCATION (City, town, or county) (State) Balto - Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Milton P. Elctson		25D. ADDRESS 1129 Marlborough			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 6813

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MARGARET FAULKNER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 5 1970 12:10 A.M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE New York B. COUNTY V-29	
9. DATE OF BIRTH 11/15/14		10. AGE (In years last birthday) 56	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Daniel R. Robinson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk	
15. MOTHER'S MAIDEN NAME Ollie Jolley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 072-20-4027		18. INFORMANT Robert Faulkner	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7-5-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 7/7/70	
24C. NAME OF CEMETERY or CREMATORY Mt. Holiness Memorial Park		24D. LOCATION (City, town, or county) (State) Butler, New Jersey	
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.	
25C. FUNERAL DIRECTOR Arlington S. Phillips		ADDRESS 1727 N. Monroe Street	

THE EXAMINER

DATE

TIME

NAME OF THE EXAMINEE

ADDRESS OF THE EXAMINEE

STATE OF THE EXAMINEE

CITY OF THE EXAMINEE

COUNTY OF THE EXAMINEE

ZIP CODE OF THE EXAMINEE

DATE OF EXAMINATION

TIME OF EXAMINATION

NAME OF THE EXAMINER

ADDRESS OF THE EXAMINER

STATE OF THE EXAMINER

CITY OF THE EXAMINER

COUNTY OF THE EXAMINER

ZIP CODE OF THE EXAMINER

DATE OF EXAMINATION

TIME OF EXAMINATION

NAME OF THE EXAMINER

ADDRESS OF THE EXAMINER

STATE OF THE EXAMINER

CITY OF THE EXAMINER

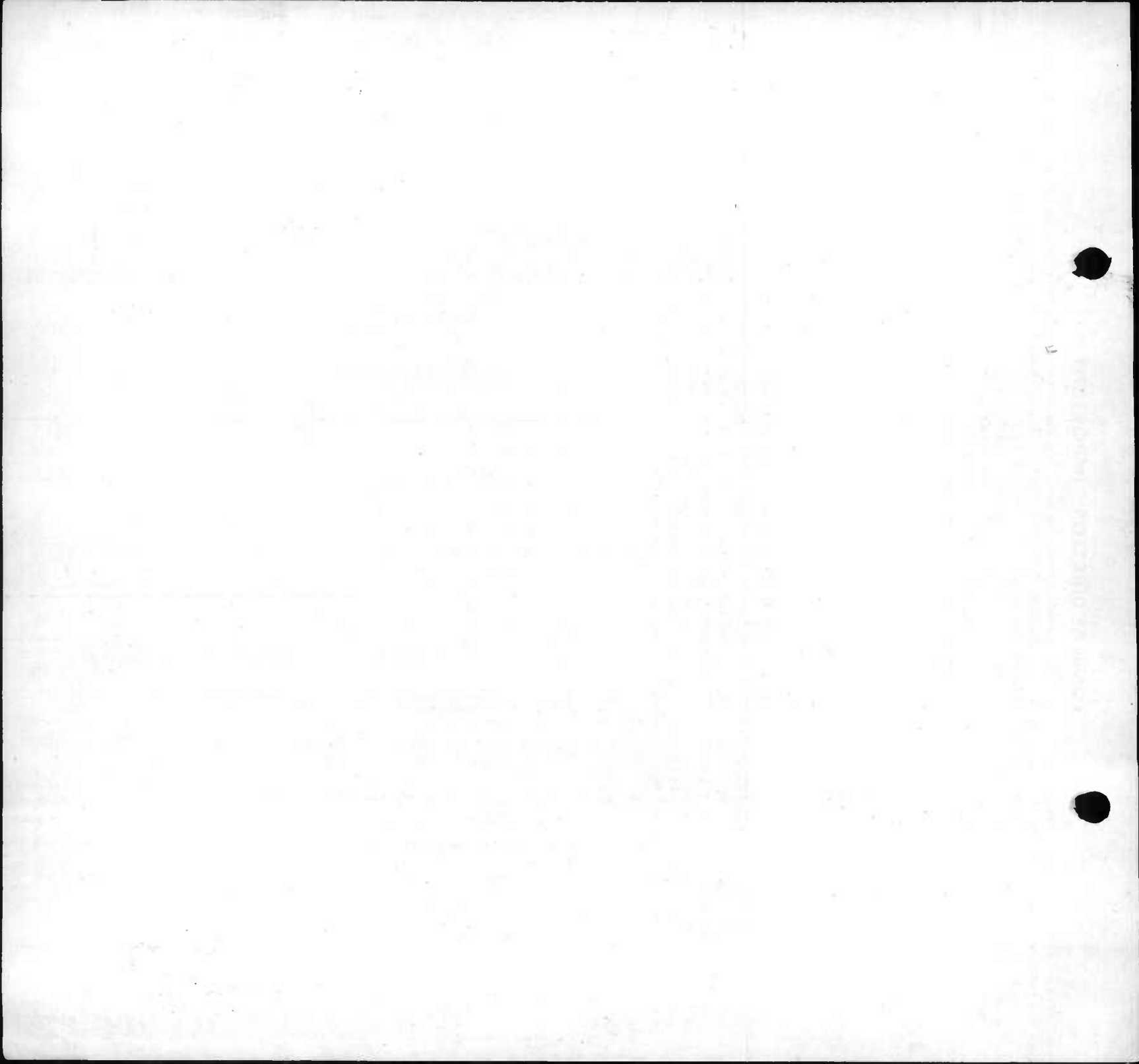
COUNTY OF THE EXAMINER

ZIP CODE OF THE EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

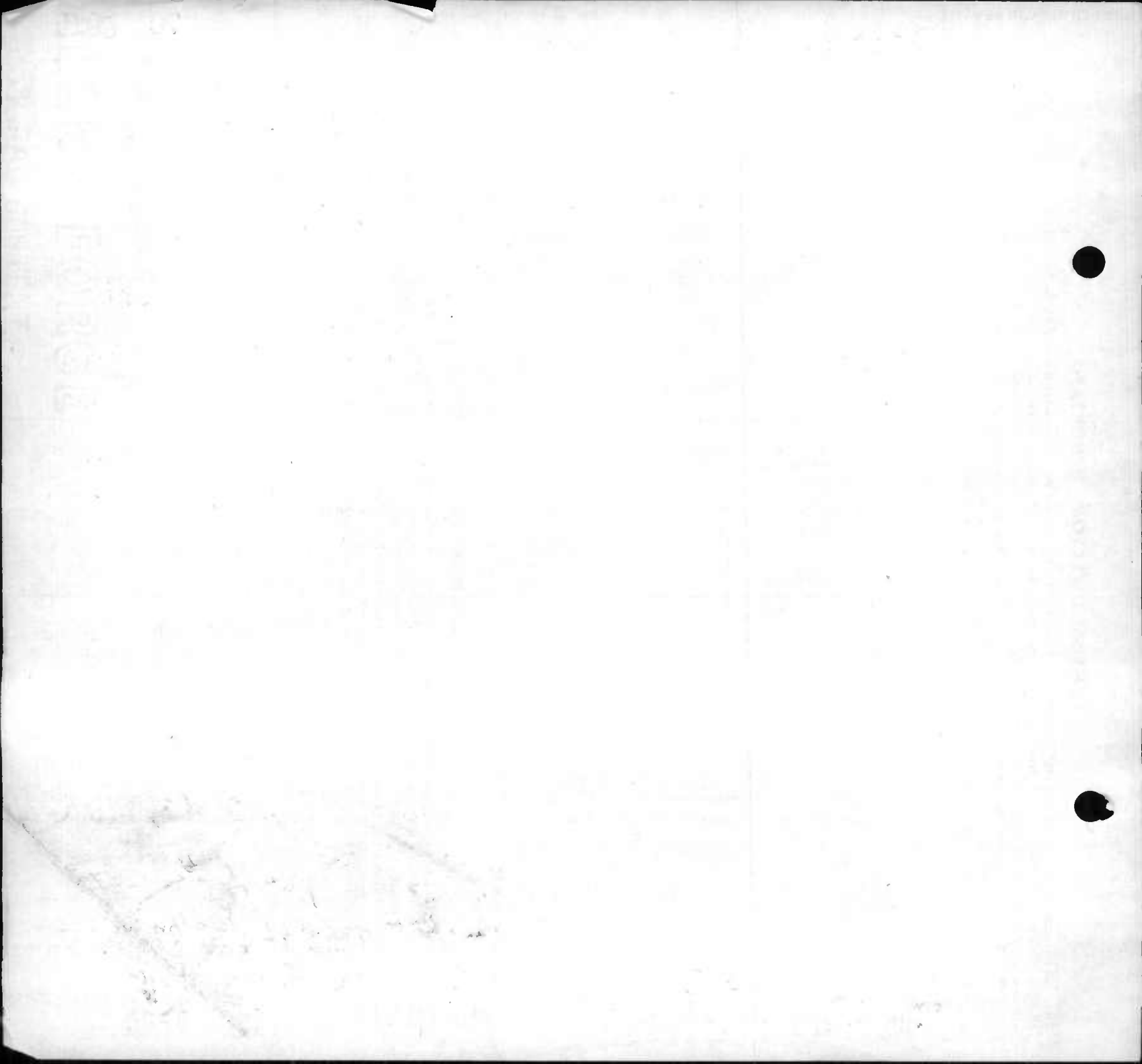
BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>70 6814</u>	
<div style="display: flex; justify-content: space-between;"> 7-260 70 6814 CERTIFICATE OF DEATH </div>						BIRTH NO. <div style="font-size: 2em; font-weight: bold;">1</div>	
1. NAME OF DECEASED (Type or Print) WILLIE MAE TUCKER				2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> JULY 5, 1970 10⁰⁰ A. M. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em; font-weight: bold;">00 2125 WALBROOK AVENUE</div>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY _____ C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2125 WALBROOK AVENUE			
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 9/13/07		9. AGE (In years last birthday) 62		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOWER ATTENDANT				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME EDWARD MCKENNEY				14. MOTHER'S MAIDEN NAME BESSIE JOHNSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. MARIAN MOORE 2125 WALBROOK AVENUE			
17. INFORMANT ADDRESS 2125 WALBROOK AVENUE							
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) 153.8T CARCINOMA of colon & metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Bronchitis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mos 5 yrs							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/11 1968</u> to <u>7/5 1970</u>, that (I) (we) last saw the deceased alive on <u>JUNE 29 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <div style="font-size: 1.5em; font-family: cursive;">Elijah Saunders</div>				23B. DATE SIGNED 7/6/70			
23C. PHYSICIAN'S NAME (Type) Elijah Saunders				23D. ADDRESS 2300 Garrison Boulevard			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/9/70		24C. NAME OF CEMETERY or CREMATORY ARBUTHNOTS MEMORIAL PARK			
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970					
25B. NAME OF REGISTRAR <div style="font-size: 1.5em; font-family: cursive;">John E. Phillips</div>		25C. FUNERAL DIRECTOR ARLINGTON S. PHILLIPS 1727 N. MONROE STREET					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	70 6815
<p>5-420 BIRTH NO. 50-07994</p> <p>1. NAME OF DECEASED (Type or Print) BABY BOY SCOLISKY</p>		<p>2. DATE AND HOUR OF DEATH 5-12-70 3-30 P.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore, Inc.</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New Born MD. B. COUNTY Baltimore</p> <p>C. CITY OR TOWN Baltimore city D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 514 S. 46th ST.</p>			
<p>5. SEX M</p>	<p>6. RACE W</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 5-9-70</p>	<p>9. AGE (In years last birthday) 3</p>	<p>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) USA</p>	
<p>12. CITIZEN OF WHAT COUNTRY? USA</p>		<p>13. FATHER'S NAME Joe H. Scolisky</p>			
<p>14. MOTHER'S MAIDEN NAME John H. Haggerty</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>			
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS Sinai Hospital of Baltimore, Inc.</p>			
<p>18. CAUSE OF DEATH</p>					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>					
<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Prematurity with respiratory distress</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>					
<p>II</p>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) No</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 5-9-70 to 5-12-70, that (I) (we) last saw the deceased alive on 5-12-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE K.C. Jan MD</p>				<p>23B. DATE SIGNED 5-12-70</p>	
<p>23C. PHYSICIAN'S NAME (Type) KADAN CHANDRA SAU MD</p>				<p>23D. ADDRESS Sinai Hospital of Baltimore, Inc.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) 7-2-70</p>		<p>24B. DATE</p>		<p>24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL</p>	
<p>24D. LOCATION</p>		<p>24E. ADDRESS MORTUARY SERVICE - BCD</p>			
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970</p>		<p>25B. NAME OF REGISTRAR Robert E. Farber, M.D.</p>		<p>25C. FUNERAL DIRECTOR ADDRESS</p>	

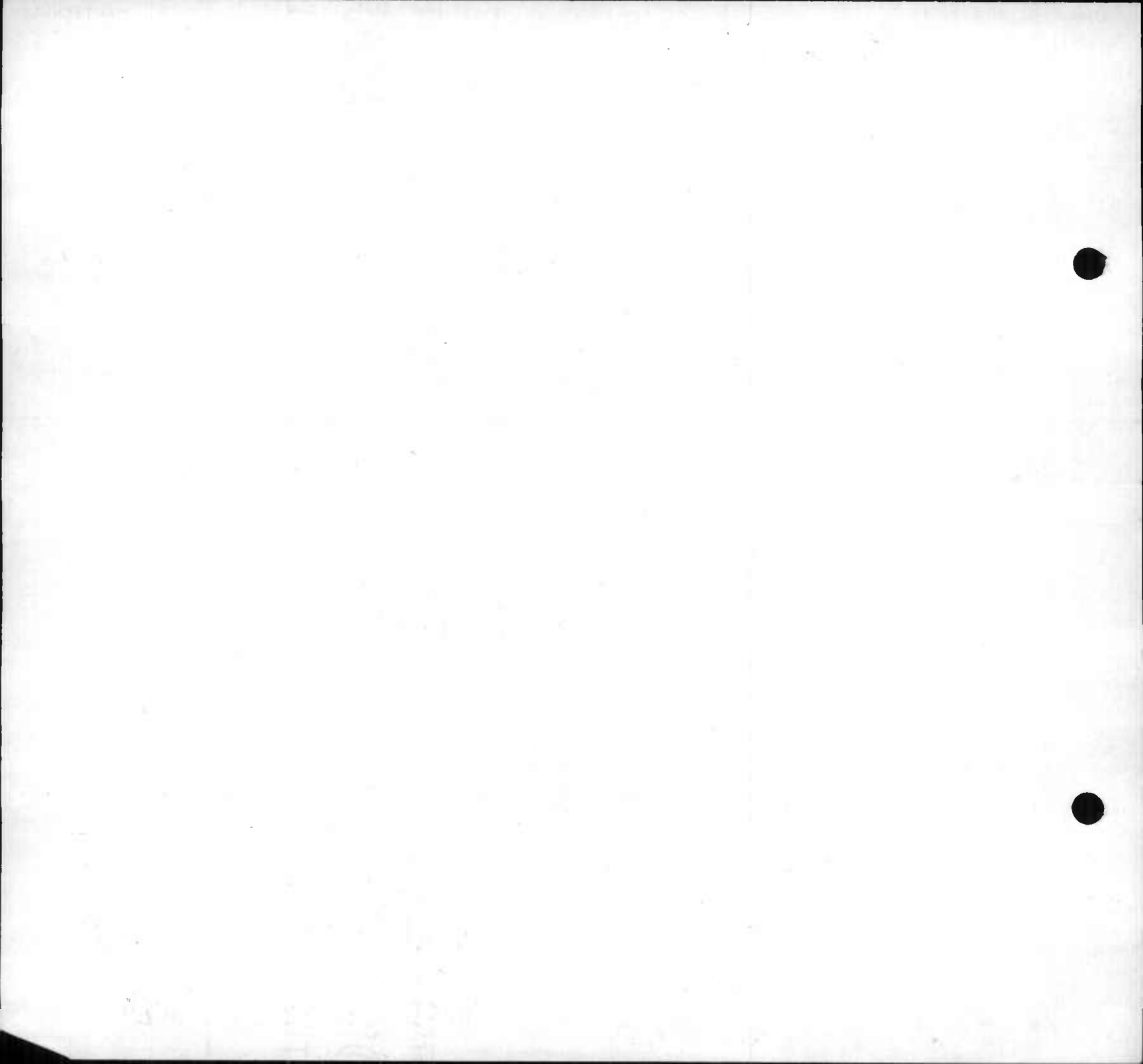


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 70 6816 4
S-362		70 6816		CERTIFICATE OF DEATH
BIRTH NO. 70-09208 Stowers				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Stowers baby Boy		5/26/70		2 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		
		B. COUNTY		
Sinai Hospital of Balto.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Balto 21207		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
M		C		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH
				5/26/70
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
Jimmie L. Stowers		Brown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 770.1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		60% Abruptio Placentae		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II		Prematurity		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 5/26 19 70 to 5/6/ 19 70 , that (I) (we) last saw the deceased alive on 5/26 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
[Signature] M.D.		5/26/70		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Carlos R. Perel		Sinai Hospital of Balto.		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
	7-2-70			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS
JUL 7 1970		Robert E. Farley, Jr.		[Signature]

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCBD



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

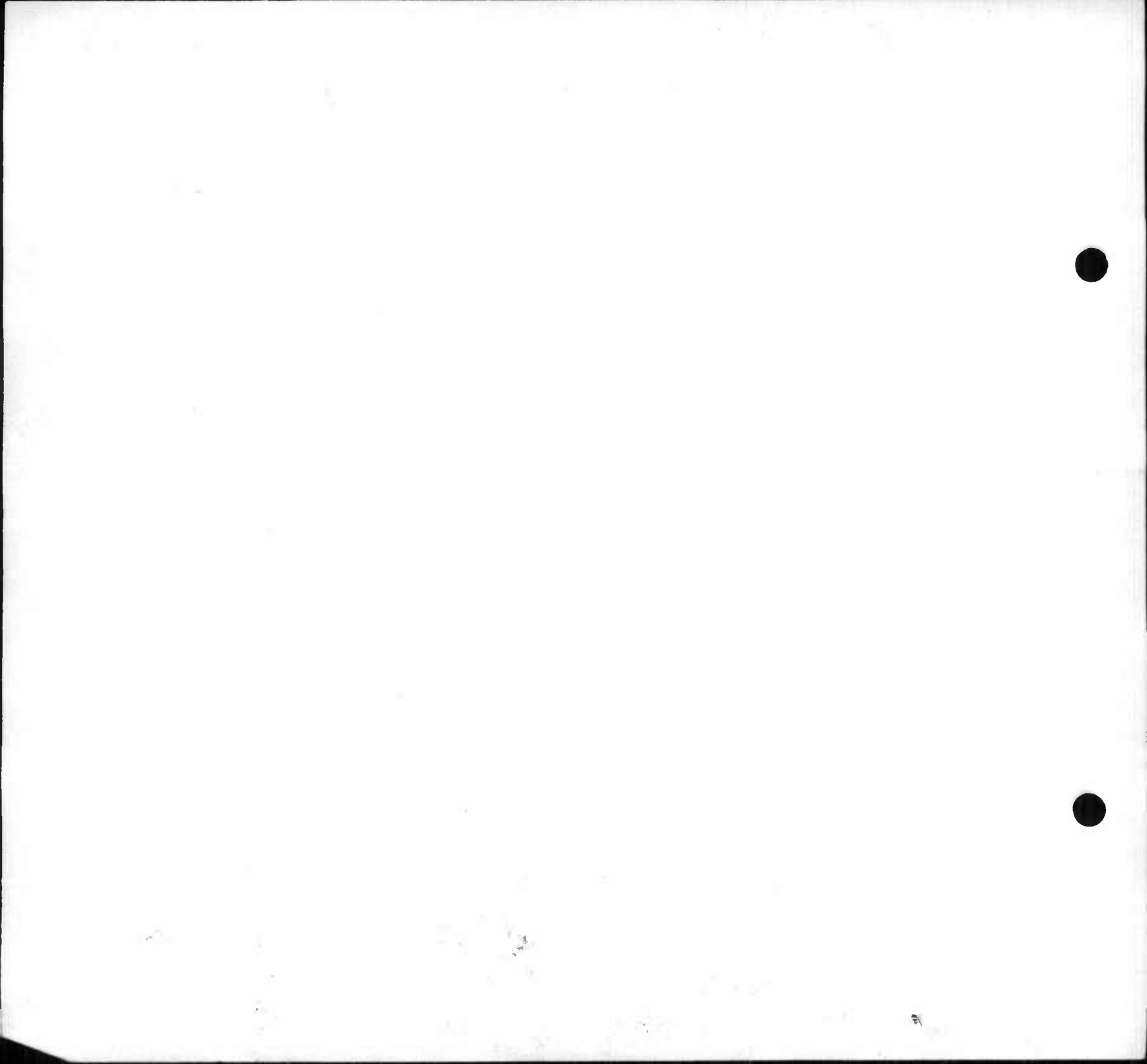
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6817 ✓	
P-200 70 6817				CERTIFICATE OF DEATH	
BIRTH NO. 70-08480		1. NAME OF DECEASED (Type or Print) PUGH Baby Girl		2. DATE AND HOUR OF DEATH 12⁵⁵am 5.17.70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital of Baltimore			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY Balto. C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2323 Rosedale st. #16.		
5. SEX F.	6. RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5.11.70	9. AGE On years (last birthday) 5 days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sinai Hospital of Balto.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Mother Courtney Michael Terry			14. MOTHER'S MAIDEN NAME Joan Pugh		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT H. KAFTARIAN M.D. ADDRESS Sinai Hospital	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Extreme prematurity DUE TO, OR AS A CONSEQUENCE OF: (B) Gestational age was 26 wks DUE TO, OR AS A CONSEQUENCE OF: (C) birth weight was 630 grams			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5.11.70 19 to 5.17.70 19 that (I) (we) lost saw the deceased alive on 5.16.70 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kaftarian M.D.			23B. DATE SIGNED 5.17.70		
23C. PHYSICIAN'S NAME (Type) KAFTARIAN M.D.			23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-2-70		24C. NAME of CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



FUNERAL DIRECTOR: IMPORTANT

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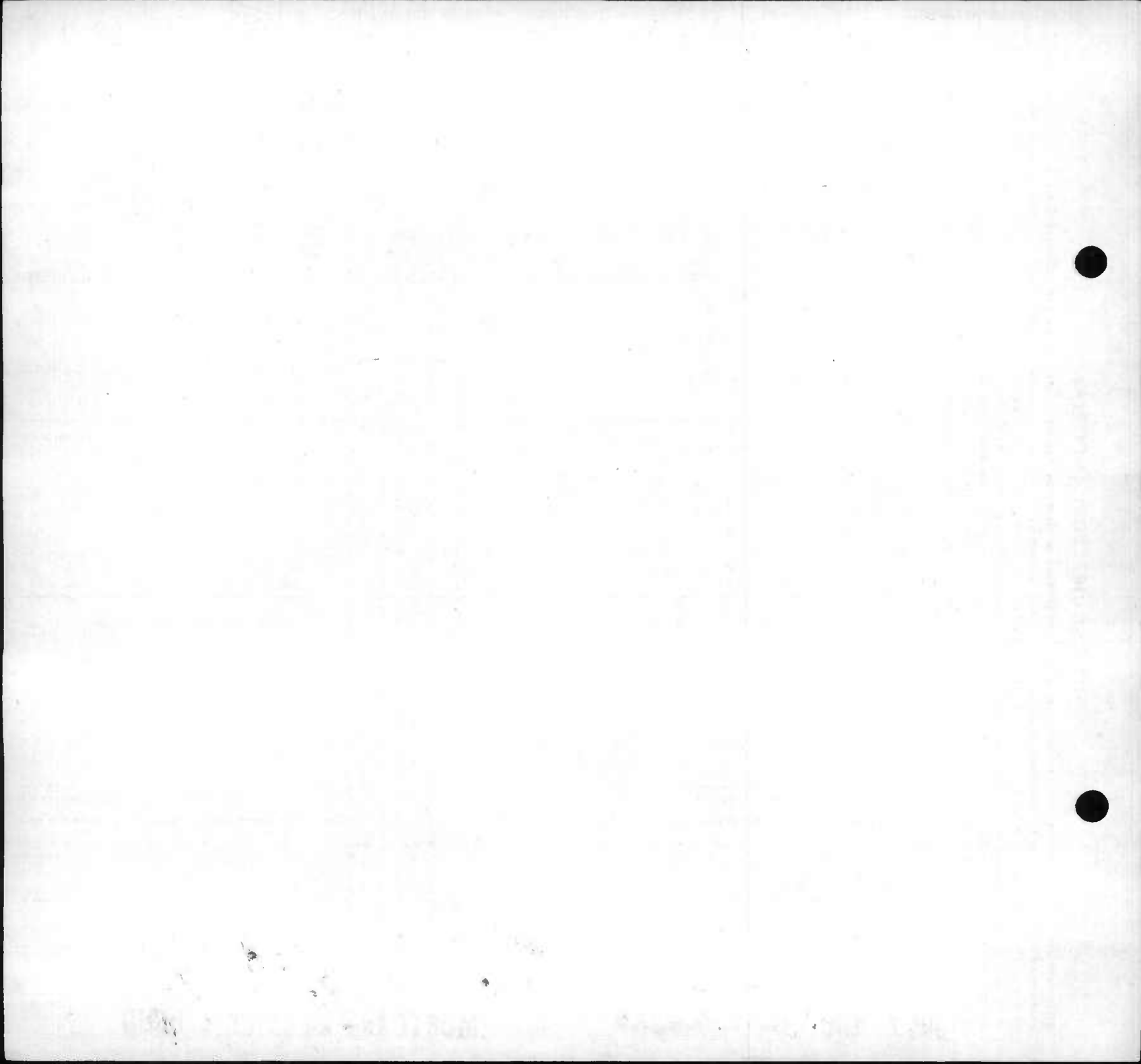
BIRTH NO. <u>70-09430</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>70 6818</u>	
1. NAME OF DECEASED (Type or Print) <u>Baby boy Hoffmaster</u>			2. DATE AND HOUR OF DEATH <u>5. 25. 70</u> <u>1 9 00</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4 Sinai Hospital of Balto.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2712</u>		
5. SEX <u>M</u>		6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5. 25. 70</u>	9. AGE (in years last birthday) <u>3</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>	12. CITIZEN OF WHAT COUNTRY? <u>—</u>
13. FATHER'S NAME <u>William Ronald.</u>			14. MOTHER'S MAIDEN NAME <u>Chary.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>H. KAFARIAN M.D.</u> ADDRESS <u>Sinai Hosp</u>		
18. <u>77871</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Cardiorespiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>pulmonary edema secondary to Hydrops</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>		
19A. DATE OF OPERATION <u>5-25-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>5-25-70</u> 19 <u>70</u> to <u>5-25-70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>5-25-70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Kaffar 9147</u>			23B. DATE SIGNED <u>5. 25. 70</u>		23C. PHYSICIAN'S NAME (Type) <u>H. KAFARIAN M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>—</u>			24B. DATE <u>7-2-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>—</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>ANTHONY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCHD</u>



FUNERAL DIRECTOR: IMPORTANT

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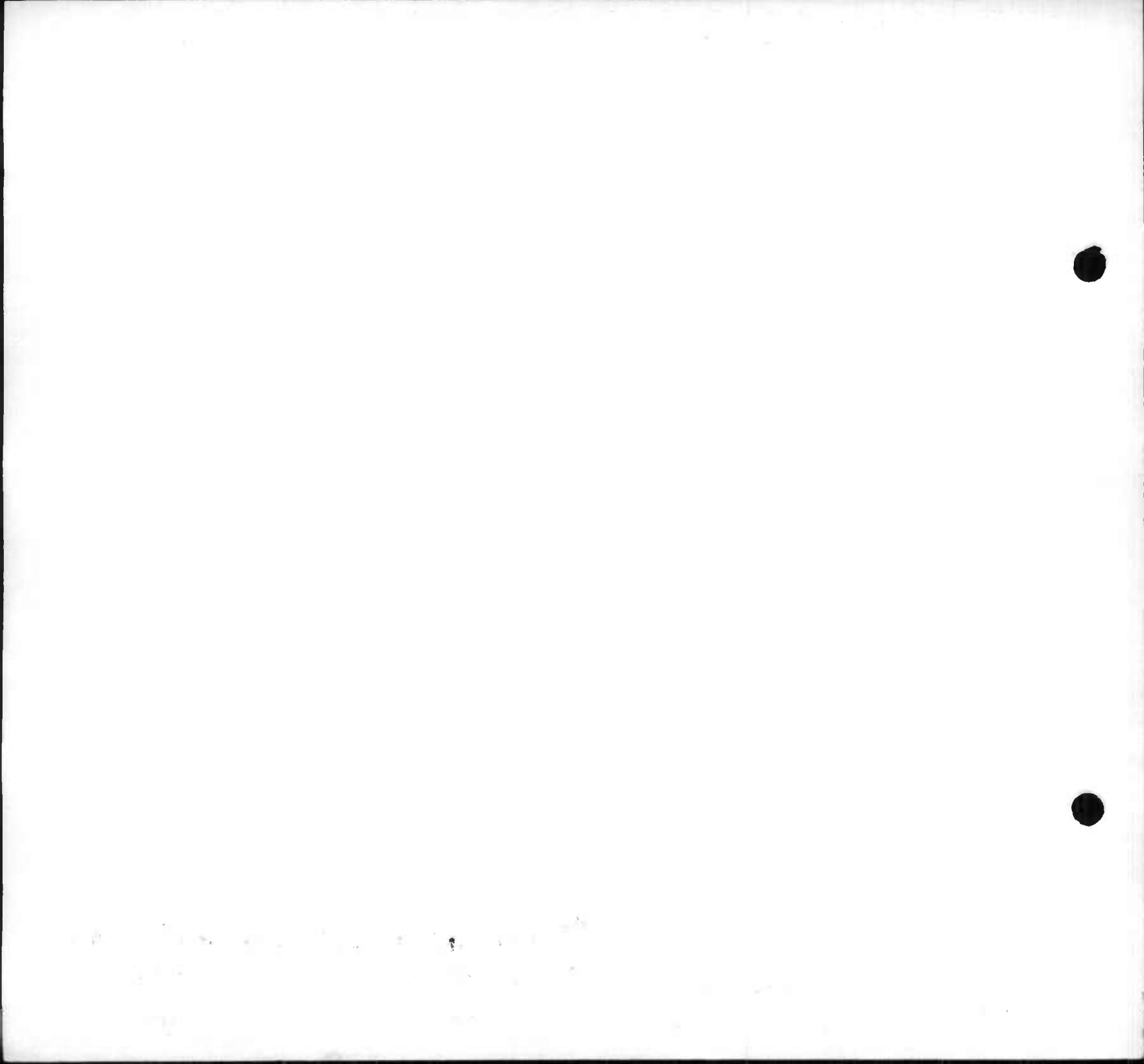
BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>70 6819</u>	
<div style="display: flex; justify-content: space-between;"> S-536 70 6819 CERTIFICATE OF DEATH </div>						<div style="display: flex; justify-content: space-between;"> 70 6819 19-30 A.M. </div>	
1. NAME OF DECEASED (Type or Print) BABY BOY SAUNDERS				2. DATE AND HOUR OF DEATH 5-26-70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore, Inc.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore			
				C. CITY OR TOWN Baltimore city		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3510 Greenpring ave Sinai Hospital of Baltimore, Inc.			
5. SEX M	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-22-70	9. AGE (In years last birthday) 4	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10B. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jimmy James Saunders				14. MOTHER'S MAIDEN NAME Sarah Whittaker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT K.C. San		ADDRESS Sinai Hosp. of Balto.	
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Immaturity DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-22-70 19 to 5-26- 19 70 , that (I) (we) last saw the deceased alive on 5-26- 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE K.C. San				23B. DATE SIGNED 5-26-70			
23C. PHYSICIAN'S NAME (Type) KADAM CHANDRA SAU MD				23D. ADDRESS Sinai Hospital of Baltimore, Inc.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-2-70		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
				ANATOMY BOARD OF MARYLAND			
				UNIVERSITY MEDICAL SCHOOL			
25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD			



FUNERAL DIRECTOR: IMPORTANT

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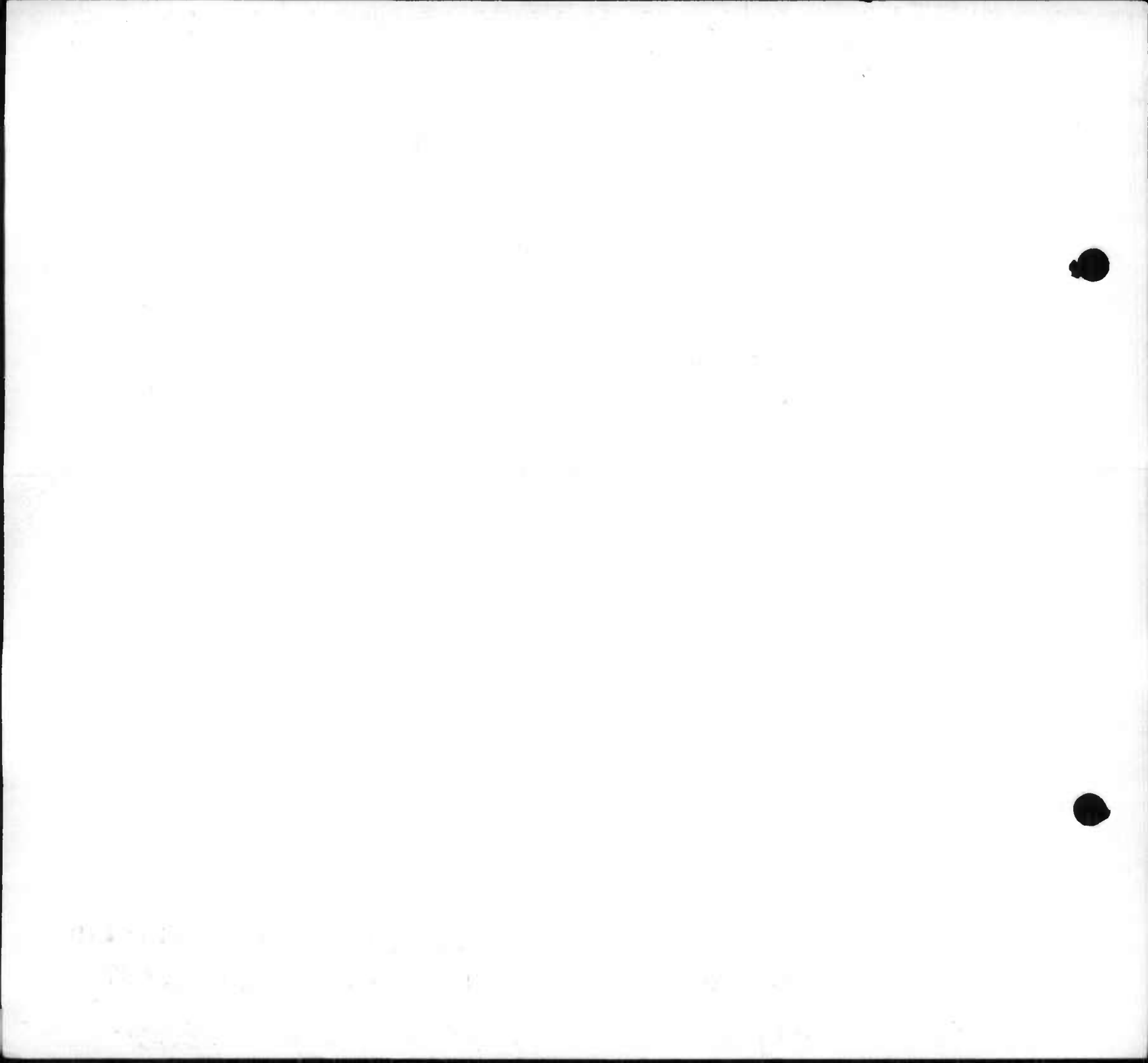
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6820</u> ✓
BIRTH NO. <u>V-545 70 6820</u>		1. NAME OF DECEASED (Type or Print) <u>VANLANDINGHAM, BABY GIRL</u>		
2. DATE AND HOUR OF DEATH <u>6-1-70 4:15 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>SINAI HOSP. BALTO, MD. 21215</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2716</u>		5. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
6. STREET AND NUMBER <u>2837 EDGECOMBE CT NO. 15</u>		7. SEX <u>♀</u> 8. RACE <u>NEGRO</u> 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10. B. KIND OF BUSINESS OR INDUSTRY		11. DATE OF BIRTH <u>5-31-70</u> 12. AGE (In years last birthday) <u>29 yrs.</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>PHYLLIS</u>		15. BIRTHPLACE (State or foreign country) <u>BALTO.</u> 16. CITIZEN OF WHAT COUNTRY? <u>USA</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Immaturity w/ multiple longitudinal birth defects</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>27 hrs.</u>
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>5-31-70</u> to <u>6-1-70</u> that (I) (we) last saw the deceased alive on <u>6-1-70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Glinda P. Tugade, M.D.</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>GLINDA P. TUGADE</u>
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>7-2-70</u>		24C. NAME of CEMETERY or CREMATORY <u>ANATOMY BOARD OF MARYLAND</u>
24D. LOCATION <u>UNIVERSITY MEDICAL SCHOOL</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 6821	
BIRTH NO. <u>G-650 70 6821</u>		REG. NO. <u>70 6821</u>	
1. NAME OF DECEASED (Type or Print) <u>GRAHAM BABY BOY</u>		2. DATE AND HOUR OF DEATH <u>6-2-70</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4 Sinai Hosp. Bkto, MD.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>1512</u>	
5. SEX <u>m</u> 6. RACE <u>negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-30-70</u> 9. AGE (In years last birthday) <u>83</u> 10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>CLYDE Graham</u>		14. MOTHER'S MAIDEN NAME <u>ODESSA Granbery</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. <u>7777 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-30-70</u> to <u>6-2-70</u> and that (I) (we) last saw the deceased alive on <u>6-2-70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Glinda P. Tugade, M.D.</u>		23B. DATE SIGNED <u>6-2-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>GLINDA P. TUGADE</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1-2-70</u>	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 7 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR		ADDRESS	
MORTUARY SERVICE - BCHD			



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

70 6822

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BABY BOY CRANE

2. DATE AND HOUR OF DEATH

6/14/70

10:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

SINAI HOSP OF BALTIMORE

BALT., Md.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE
MD.B. COUNTY
BALT

C. CITY OR TOWN

BALT, PIKESVILLE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4123 ROMS

4123 ROMS RD

5. SEX

M

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6/14/70

9. AGE (In years
lost birthday)

10. Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

17

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

NEWBORN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Richard

14. MOTHER'S MAIDEN NAME

NANCY

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

CHART

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Prematurity

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

17 hrs

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Resp. Distress Syndrome

14 hrs

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (A) (this hospital) attended the deceased from 6/14/70 to 6/14/70
that (B) (we) last saw the deceased alive on 6/14/70 and that in (C) (my) opinion death occurred on the date
and hour and from the causes stated above. (D) (we) (did) (not) view the body after death.

23A. SIGNATURE

Edward N. Zissman M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

6/14/70

23C. PHYSICIAN'S
NAME (Type)

EDWARD N. ZISSMAN M.D.

23D. ADDRESS

ANATOMY BOARD OF MARYLAND

24A. BURIAL CREMATION
REMOVAL (Specify)

24B. DATE

7-2-70

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

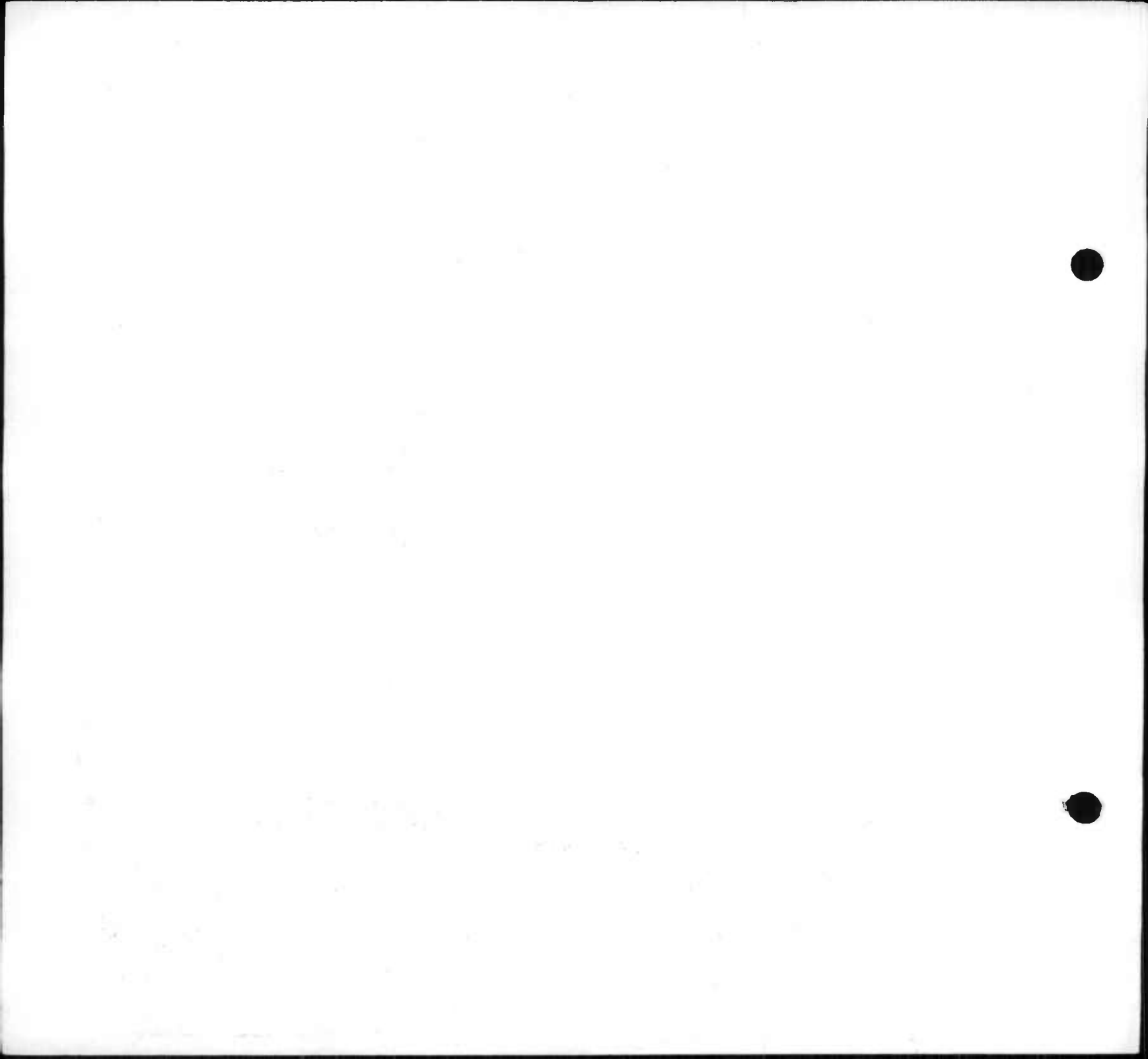
JUL 7 1970

R. E. Taylor, M.D.

MORTUARY SERVICE - BCHD

FUNERAL DIRECTOR: IMPORTANT

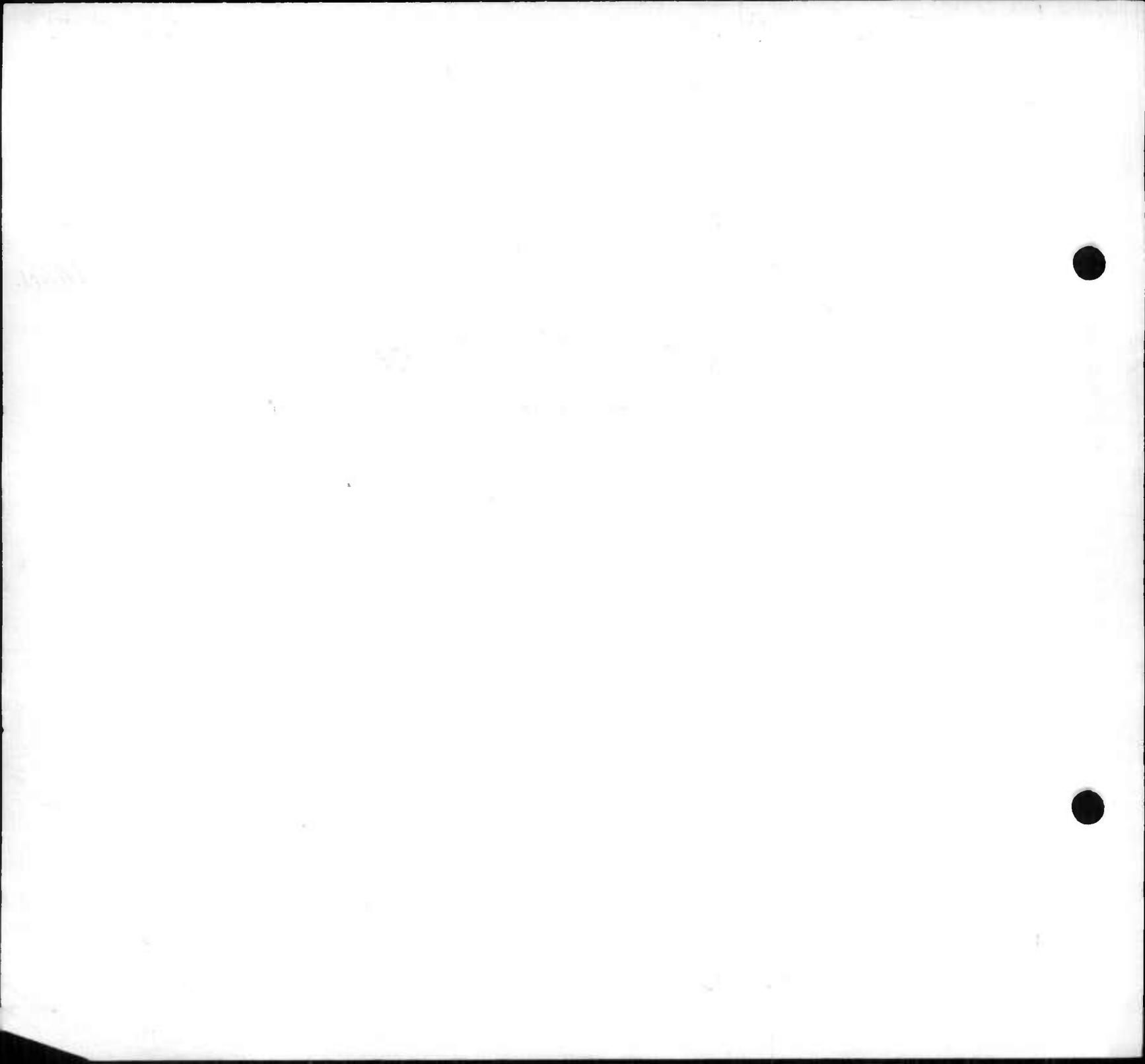
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>T-120 70 6823</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 70 6823 4</p>	
<p>BIRTH NO. 70-10854</p>		<p>2. DATE AND HOUR OF DEATH 6-22-70</p>	
<p>1. NAME OF DECEASED (Type or Print) BABY BOY TOBIAS A.</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNIVERSITY OF MARYLAND HOSPITAL.</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY calvert co.</p>		<p>5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH 6-22-70 9. AGE (In years last birthday) NB.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn</p>	
<p>11. BIRTHPLACE (State or foreign country) BALTO, MD.</p>		<p>12. CITIZEN OF WHAT COUNTRY USA</p>	
<p>13. FATHER'S NAME EUGENE Matthews Tobias</p>		<p>14. MOTHER'S MAIDEN NAME Idell Mae GGS</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT</p>		<p>ADDRESS</p>	
<p>18. 77501 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>(A) IMMEDIATE CAUSE SEVERE HYDROPS FETALIS DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Rh INCOMPATIBILITY DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) MARKED PREMATURITY.</p> <p>BIRTH.</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 6-22-70 to 6-22-70 that (I) (we) last saw the deceased alive on 6-22-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE J. Garcia</p>		<p>23B. DATE SIGNED 6-22-70</p>	
<p>23C. PHYSICIAN'S NAME (Type) JORGE E GARCIA</p>		<p>23D. ADDRESS ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) 7-2-70</p>		<p>24B. DATE</p>	
<p>24C. NAME OF CEMETERY or CREMATORY</p>		<p>24D. LOCATION (City, town, or county) (State)</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 7 1970</p>		<p>25B. NAME OF REGISTRAR Robert E. Farber, M.D.</p>	
<p>25C. FUNERAL DIRECTOR</p>		<p>ADDRESS MORTUARY SERVICE - BCHD</p>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6824

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mary Alma Maxwell

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

7

5

70

9:45 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

4377 Sheldon Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

7

5

70

9:45 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

6. SEX

female

7. RACE

white

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

9/13/15

10. AGE (in years
last birthday)

55

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

4377 Sheldon Avenue

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Leo J. McCarthy

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Catherine R. Streb

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

213-52-1695

18. INFORMANT

Vernon L. Maxwell same

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
yes22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural cause ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒DATE SIGNED
7/6/7024A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/9/70

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer

24D. LOCATION

(City, town, or county)

(State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1970

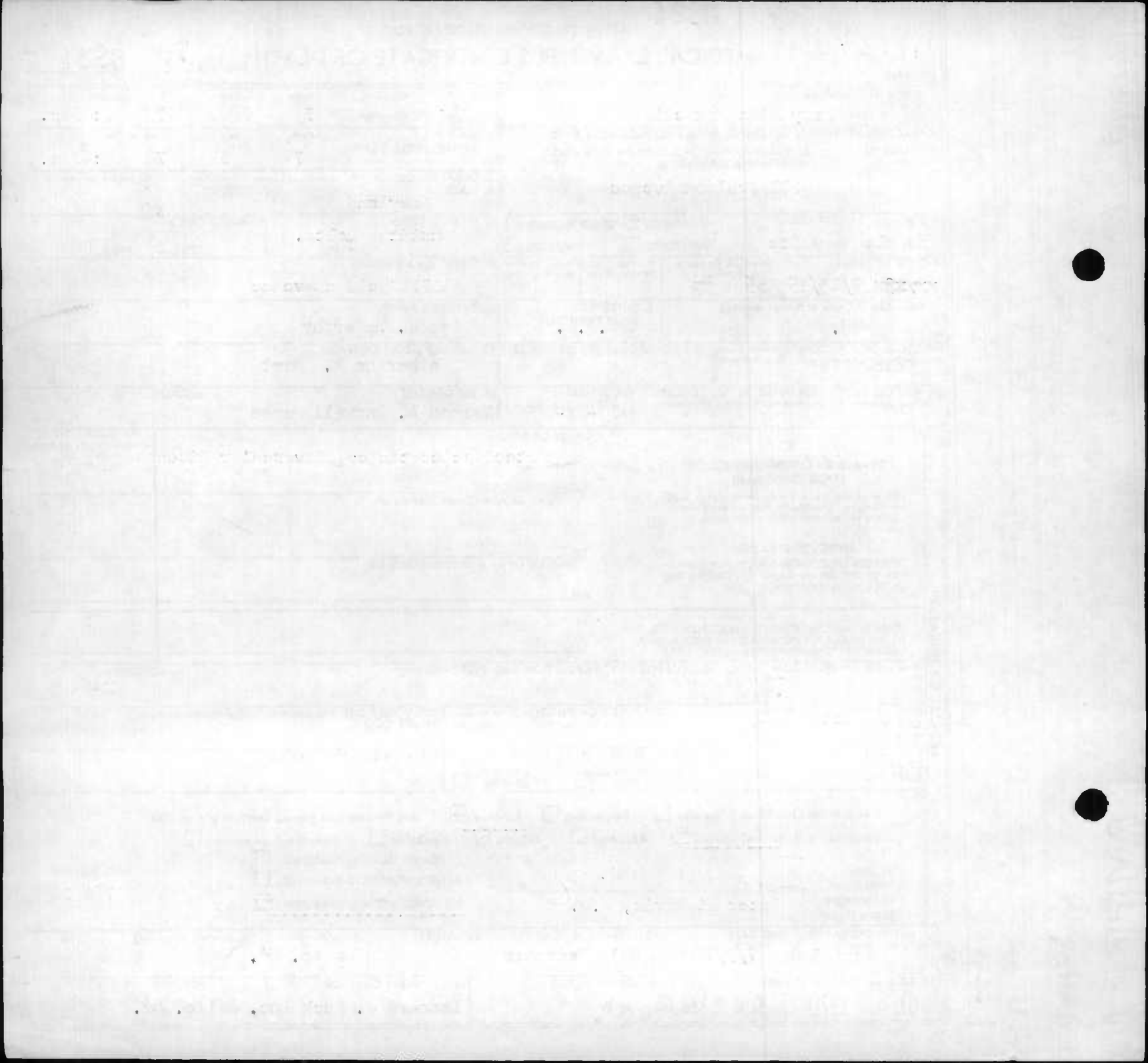
25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. Md.

ADDRESS



B-363

70

6825

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

6825

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Elizabeth Batterden

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month Day

Year

Hour

7 5

70

10:45 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3632 Yolanda Road

3. DATE
PRONOUNCED DEAD

Month Day

Year

Hour

7 5

70

10:45 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

903

6. SEX

female

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

1/17/1905

10. AGE (In years
last birthday)

68 65

11. Under 1 Yr. 12 Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3632 Yolanda Rd.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Noonan

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Nora

Quirk

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

212-32-8971

18. INFORMANT

James E. Batterden

ADDRESS

same

19.

712.41

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

7/6/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/9/70

24C. NAME of CEMETERY or CREMATORY

Parkwood Cem.

24D. LOCATION

(City, town, or county)

(State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 8 1970

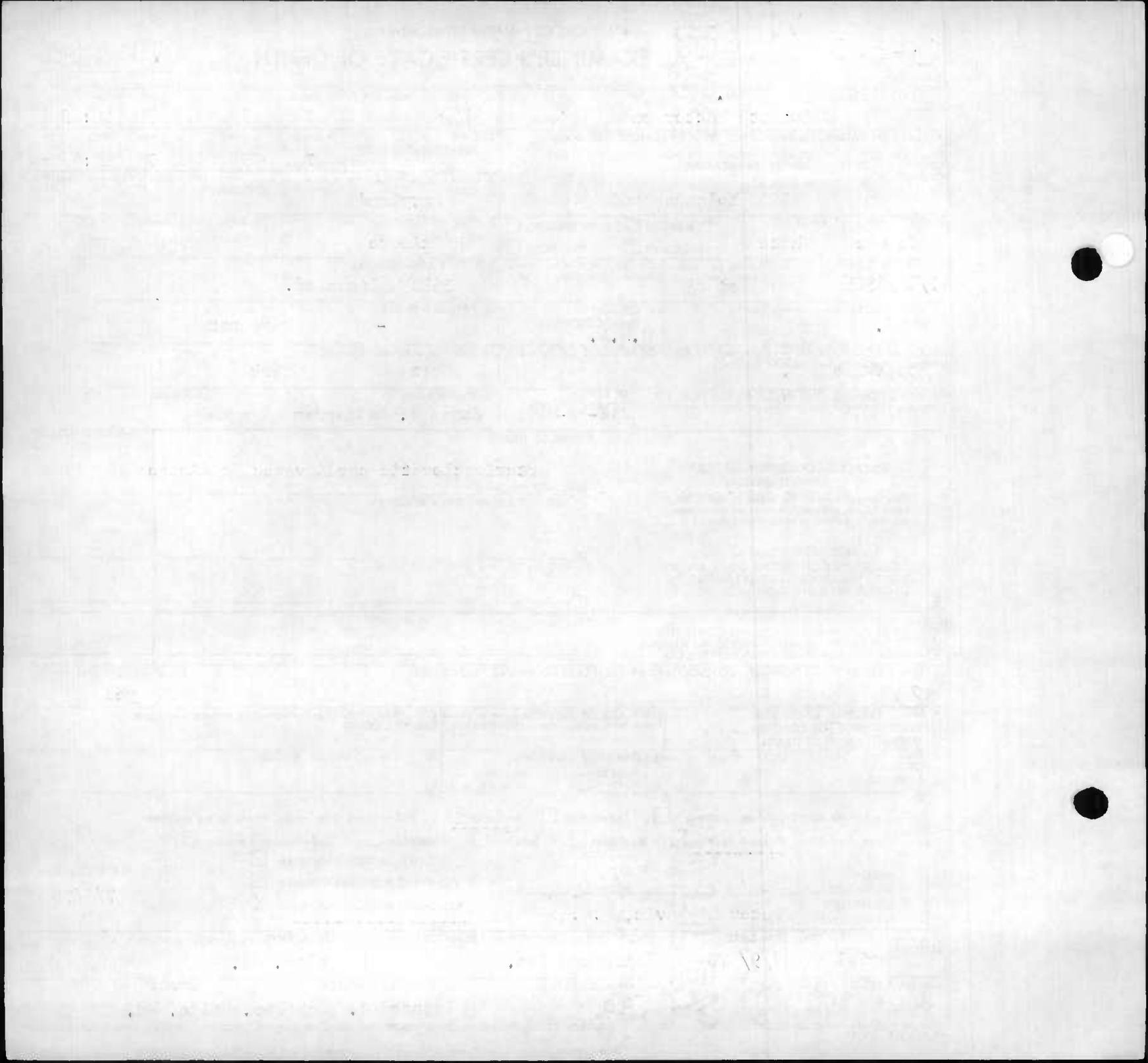
25B. NAME OF REGISTRAR

Robert E. Tabor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

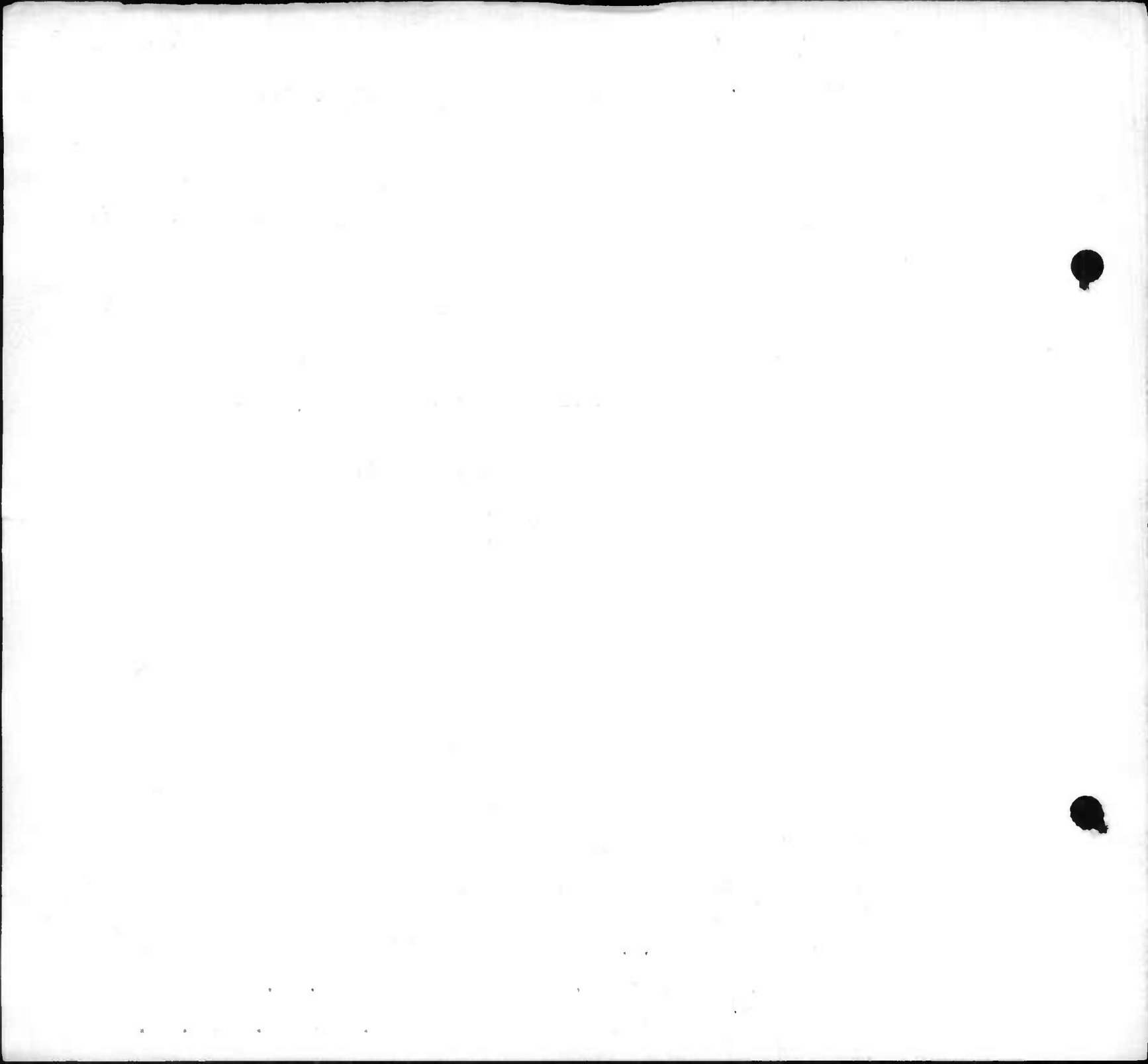
Leonard J. Ruck Inc. Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

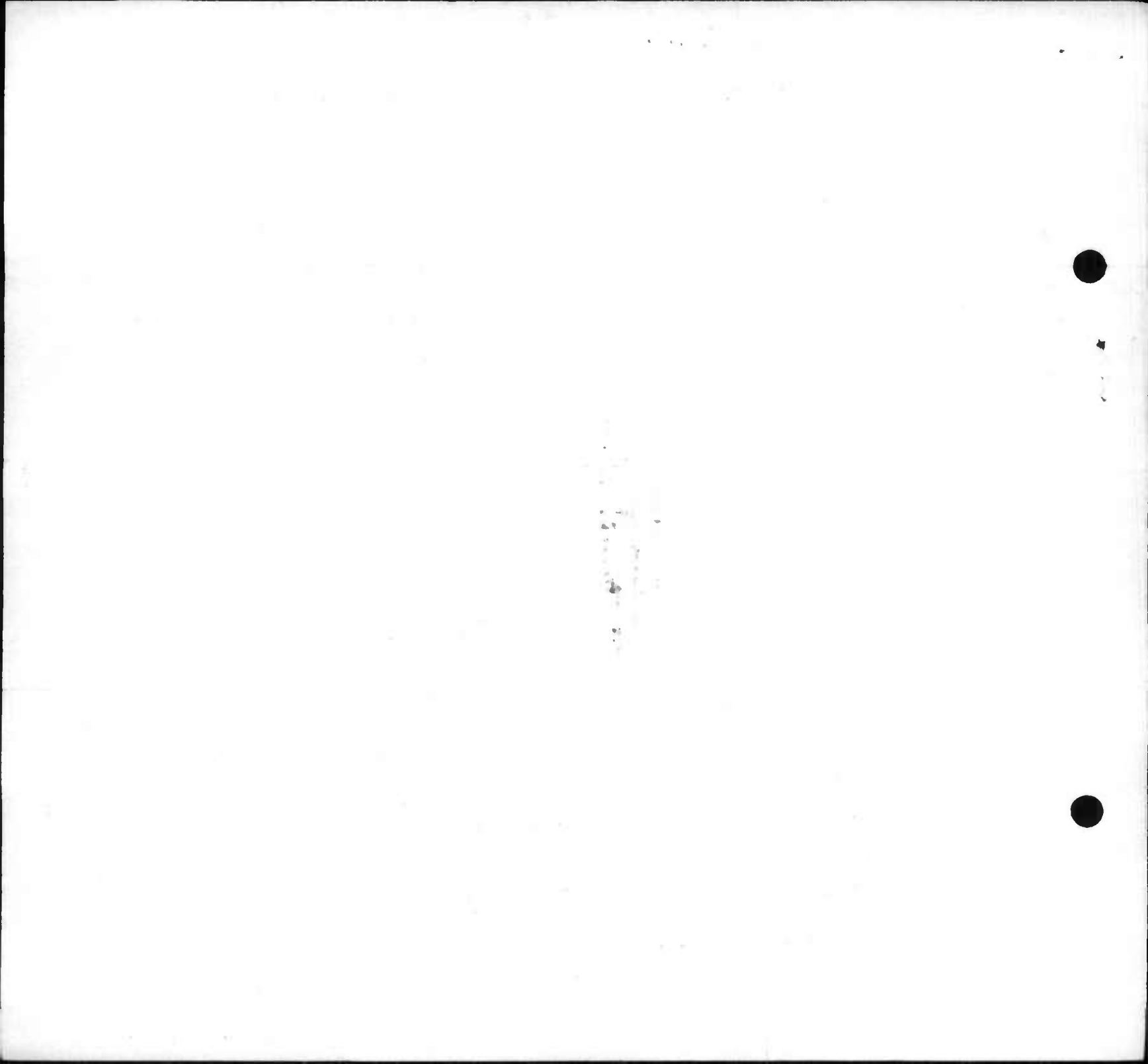
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6826</u>	
BIRTH NO. <u>70 6826</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Mildred L. Brooks</u>			2. DATE AND HOUR OF DEATH <u>July 5, 1970</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2757</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2903 Rosalie Ave Balto 34</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/31/07</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, MD</u>	
13. FATHER'S NAME <u>Thomas Wagley</u>			14. MOTHER'S MAIDEN NAME <u>Lula Reed</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-14-9434</u>		17. INFORMANT ADDRESS <u>Lorine Kelly 520 S. Tolna Street</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute MI?</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASHD</u> <u>Disturbance</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHF - old MI -</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/6/69</u> 19__ to <u>7/5/70</u> 19__ that (I) (we) last saw the deceased alive on <u>6/18/70</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J.B. Ramirez MD</u>				23B. DATE SIGNED <u>7/6/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jorge B Ramirez M.D.</u>				23D. ADDRESS <u>Hospital Drive Glen Burnie Maryland 21061</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Pk.</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. Balto. Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

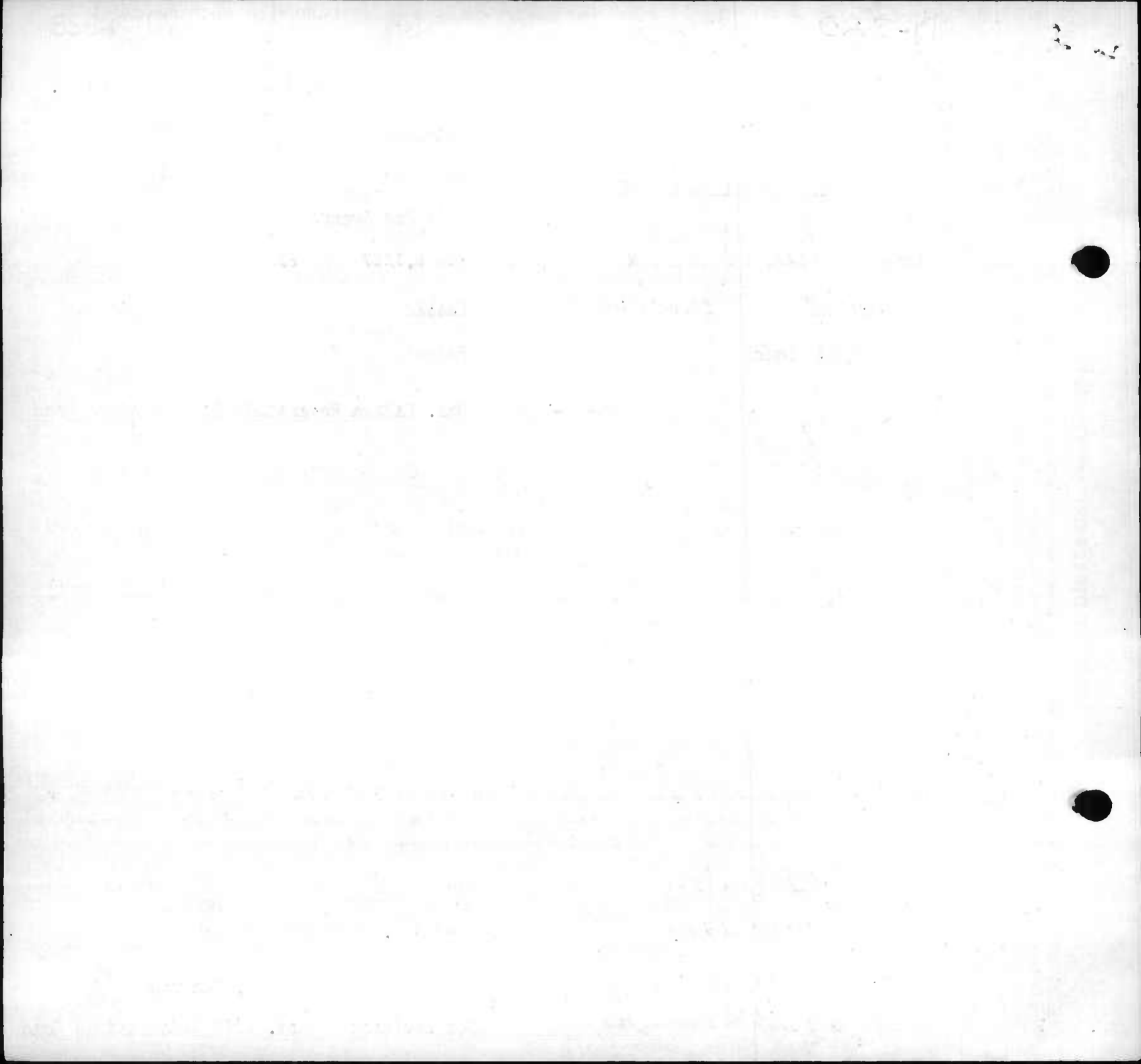
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6827	
P-640 70 6827				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		RUTH H. PROWELL		July 4, 1970 11:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE	
90 Gould Convalesarium				Maryland	
				C. CITY OR TOWN	
				Dundalk	
				D. INSIDE CITY LIMITS?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER	
				2522 Liberty Parkway	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	March 31, 1892	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
At home			Penna.		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
? Hiller			Virginia F. Berge		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No			217-56-8521		W. Richard Prowell, 2547 Liberty Parkway
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			IMMEDIATE CAUSE		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
II			PARKINSON'S Disease -		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			2 1/2 Mos		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
4/21/70		Fractured Right Hip		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No		Home		Fall - 25th St Lk Pk -	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
April 20 - 70 PM		While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		Fall m stairs	
22. I certify that (I) (this hospital) attended the deceased from April 20 1970 to July 4 1970 that (I) (we) last saw the deceased alive on July 4 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M.B. Davis				July 6-1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M.B. Davis, M.D.				6800 Morningside Road.	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		7/7/70		Cedar Hill Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Brooklyn, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR, ADDRESS	
JUL 8 1970		Robert E. Seiber, M.D.		Ullrich Funeral Home, Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

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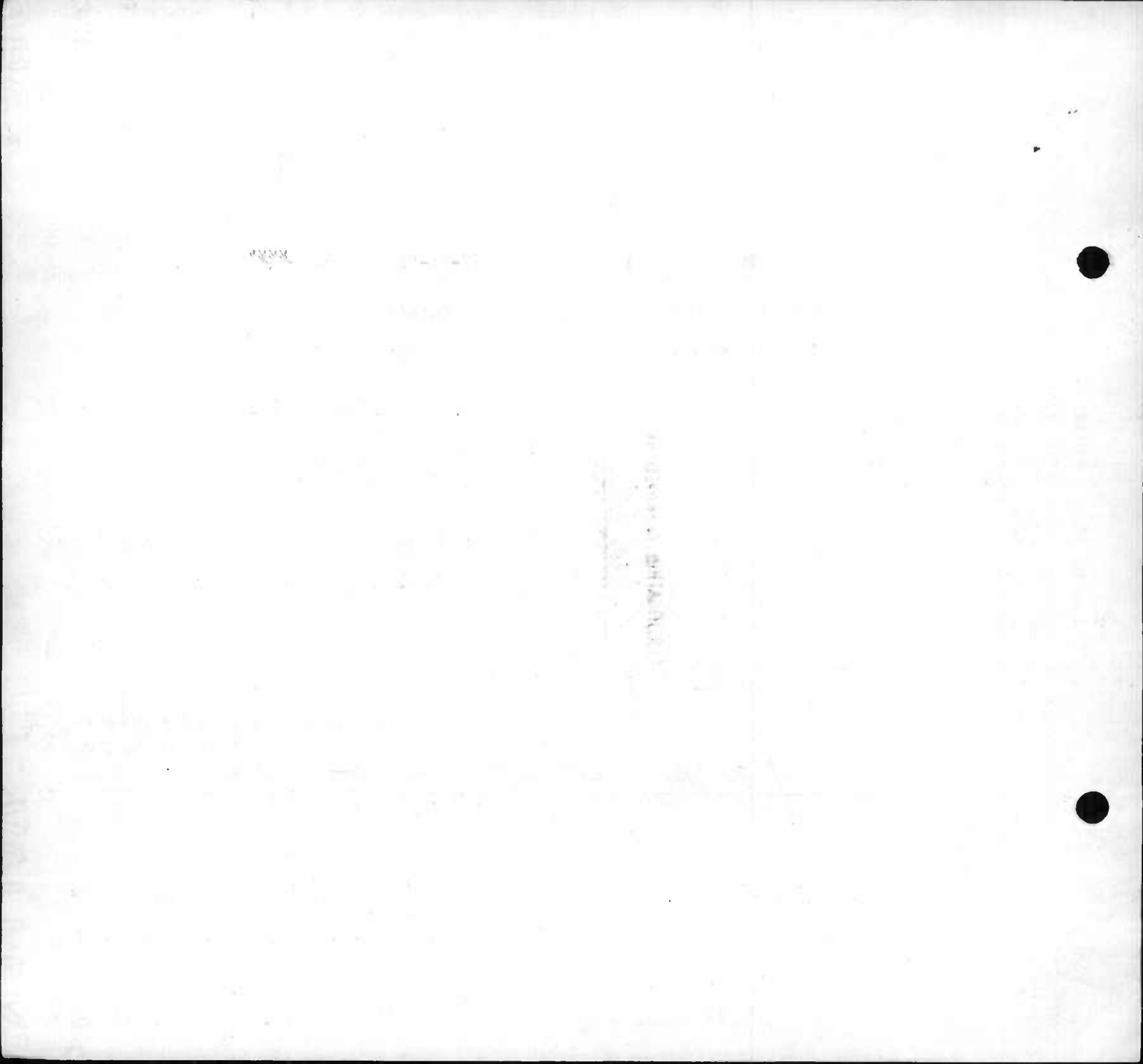
BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. 70 6828
D-320 70 6828						CERTIFICATE OF DEATH
BIRTH NO. _____						
1. NAME OF DECEASED (Type or Print) MAX DATCH			2. DATE AND HOUR OF DEATH JULY 3, 1970 5:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 JEWISH CONVELESANT HOME			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2717			
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER 4918 Poe Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1887	9. AGE (In years last birthday) 83	II Under 1 Yr. Months: _____ Days: _____ II Under 24 Hrs. Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Stone's Bakery		11. BIRTHPLACE (State or foreign country) Russia		
12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Abraham Datch			14. MOTHER'S MAIDEN NAME Faiga ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-7095		17. INFORMANT Mrs. Esther Rosenstadt 2704 Geartner Road		
18. CAUSE OF DEATH 4/12/1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C. V. A. (B) H A S H I D DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 17 years						
II						
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____						
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, lactory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____		
22. I certify that (I) (this hospital) attended the deceased from 7/1 19 76 to 7/3 19 70 , that (I) (we) last saw the deceased alive on 7/1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Israel Zinberg				23B. DATE SIGNED 7/3/70		
23C. PHYSICIAN'S NAME (Type) Israel Zinberg				23D. ADDRESS 4000 W. Northern Parkway		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/70		24C. NAME OF CEMETERY or CREMATORY Shaarei Tfiloh		
24D. LOCATION Baltimore, Maryland						
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road		



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6829
G-355 70 6829		BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <i>Benjamin Goodman</i>		2. DATE AND HOUR OF DEATH <i>7/2/70 2:50 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Bolton Hill Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1512</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bolton Hill Nursing Home</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <i>3916 Reisterstown Road</i>		
5. SEX <i>male</i>	6. RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-25-96</i>	9. AGE (In years) <i>73</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retail Merchant</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Morris Goodman</i>		
14. MOTHER'S MAIDEN NAME <i>Ida ?</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Ronald Goodman 1429 Bolton Street # 17</i>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>E887 IX</i>		M. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Decubiti and Emaciation</i> (B) <i>Fracture of hip</i> (C) <i>Hypertensive cardiovascular disease</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last. <i>II</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Weeks</i> <i>May 4, 1970</i> <i>Sharp</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <i>6-5-7-70</i>		19B. CONDITION WHEN OPERATION WAS PERFORMED <i>Fracture of hip</i>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Nursing Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Bolton Hill - Johns & Lafayette</i>
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>5 4 70 8PM</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>Fell from Bed</i>
22. I certify that (I) (this hospital) attended the deceased from <i>5/22/70</i> 19 <i>70</i> to <i>7/2</i> 19 <i>70</i> , and that (I) (we) lost saw the deceased alive on <i>7/2</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Peter H. Rheinstein, MD</i>				23B. DATE SIGNED <i>July 2, 1970</i>
23C. PHYSICIAN'S NAME (Type) <i>PETER H. RHEINSTEIN, MD</i>				23D. ADDRESS <i>1111 Park Avenue, Baltimore, MD 21201</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/5/1970</i>		24C. NAME OF CEMETERY or CREMATORY <i>Posvohler Friendly Society</i>
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE RECEIVED BY HEALTH DEPT. <i>JUL 8 1970</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR <i>Sol Levinson & Bros. 6010 Reisterstown Road</i>		



FUNERAL DIRECTOR: IMPORTANT

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G-435 70 6830		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 6830	
1. NAME OF DECEASED (Type or Print) GOLDMAN, JOSEPH R.		2. DATE AND HOUR OF DEATH 7-3-70 12:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE UNION MEMORIAL HOSPITAL BALTIMORE, MARYLAND 21218		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY P. George C. CITY OR TOWN BLADENSBURG D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5303 VARNUM STREET			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 67 years	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN Taxi Cab		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? AMERICAN U.S.A.
13. FATHER'S NAME LOUIS GOLDMAN		14. MOTHER'S MAIDEN NAME FANNIE SOLOMON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO.		17. INFORMANT Bladensburg, Maryland 20770 Mr. Lee E. Goldman 5303 Varnum St.	
18. 440.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
19A. DATE OF OPERATION 6/15/1970		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene Right foot		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 6/10/70 1970 to 7/3/1970 19 that (1) (we) last saw the deceased alive on 7/2/1970 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. V. K. Shetty		23B. DATE SIGNED 7/3/1970		23C. PHYSICIAN'S NAME (Type) DR. V. K. SHETTY M.D. B.S.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/1970		24C. NAME OF CEMETERY OR CREMATORY Chizuk Amuno	
24D. LOCATION Baltimore, Maryland		24E. ADDRESS THE UNION MEMORIAL HOSPITAL BALTIMORE, MARYLAND		24F. ADDRESS 6010 Reisterstown Road	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Sol Levinson & Bros.	

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NEW YORK, N.Y.

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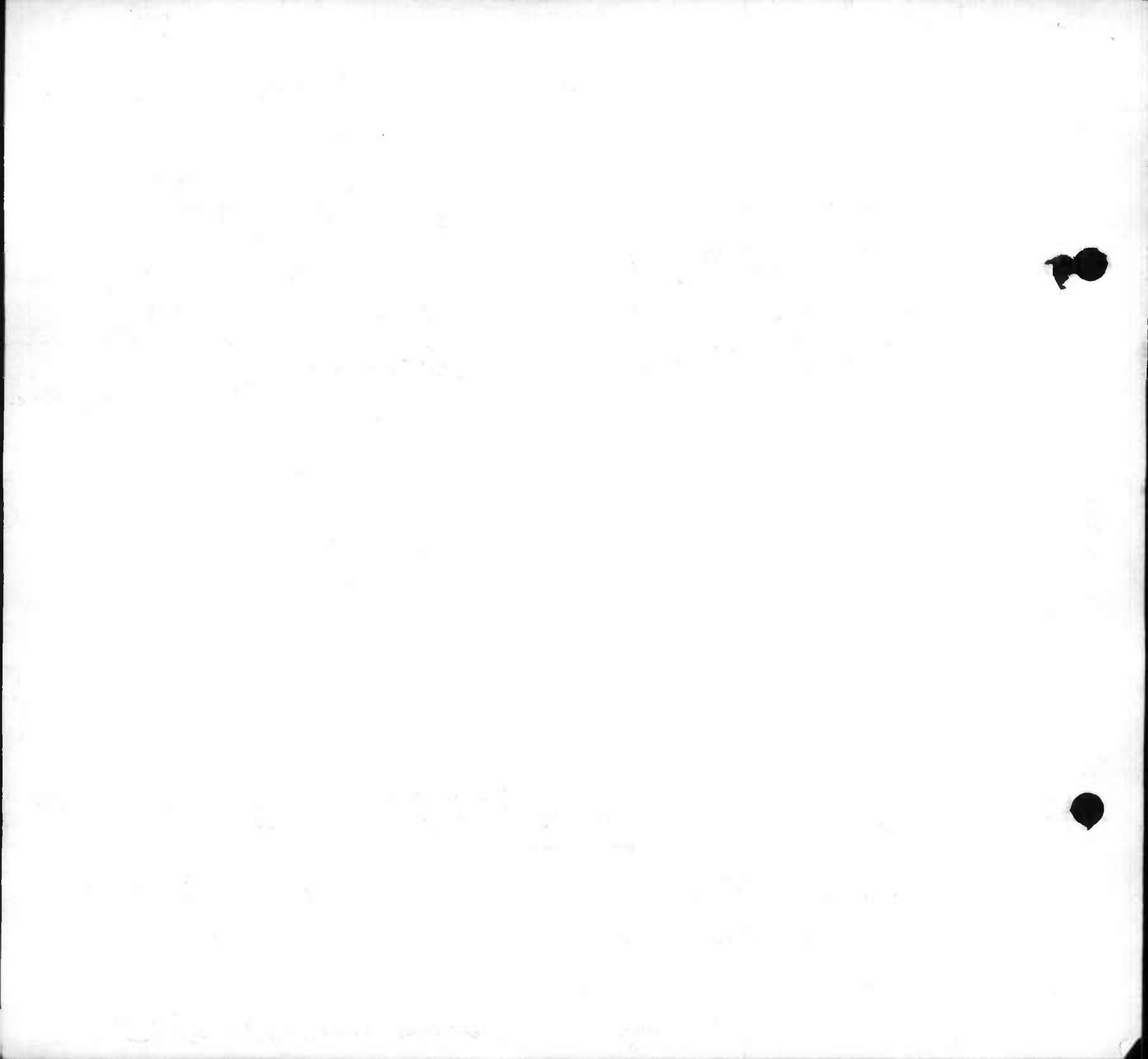
NEW YORK, N.Y.

NEW YORK, N.Y.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-325 70 6831		BALTIMORE CITY HEALTH DEPARTMENT		70 6831	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) REBECCA KATZEN		2. DATE AND HOUR OF DEATH 7/3/70 6:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6516 Armstrong Ave			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 87		9. AGE (In years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME Zelev Katzen		14. MOTHER'S MAIDEN NAME Hannah ?			
15. Was deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Hannah Lewis ADDRESS 6516 Armstrong Ave	
18. 41091725019		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Acute Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF: (B) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (C) ASCVD + DIABETES.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 22 1970 to July 3 1970 that (I) (we) last saw the deceased alive on July 3 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph Epstein M.D.		23B. DATE SIGNED 7/3/70		23C. PHYSICIAN'S NAME (Type) RALPH EPSTEIN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/5/70		24C. NAME OF CEMETERY or CREMATORY Temple Israel	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR 6010 Perist Rd. Sol Levinson - Brooklyn	

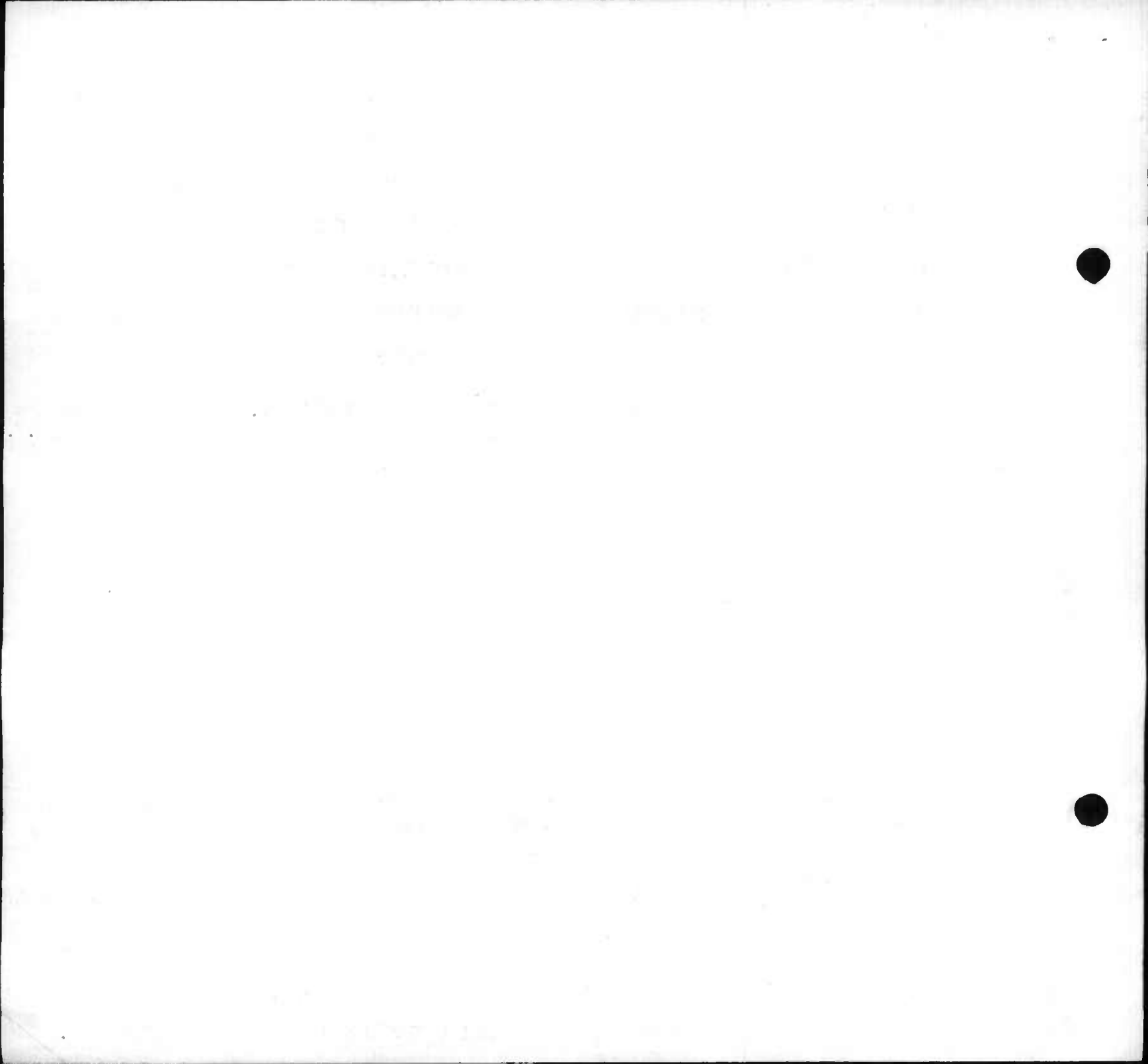


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-163		70 6832		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 70 6832	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) DAVID SAPERTON, SR.				07-05-70 10:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				A. STATE NEW YORK B. COUNTY NEW YORK			
5. SEX MALE				6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER				10B. KIND OF BUSINESS OR INDUSTRY MUSIC		8. DATE OF BIRTH 10-29-89	
13. FATHER'S NAME NAHUM SAPERSTEIN				14. MOTHER'S MAIDEN NAME NATALIE MICHALOWSKI		9. AGE (in years last birthday) 80	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 075-20-6453		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
18. 15411 CAUSE OF DEATH				12. CITIZEN OF WHAT COUNTRY? USA			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac & Respiratory arrest 5 minutes (B) Terminal Bladder Ca i metastasis DUE TO, OR AS A CONSEQUENCE OF: (C) 2nd Uremia due to ureteral obstruction			
MEDICAL CERTIFICATION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				20A. AUTOPSY? (Yes or No) yes			
19A. DATE OF OPERATION 2/19/70				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Rectum		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) /				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) /		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) /	
21D. TIME OF INJURY (APPROX.) /				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? /	
22. I certify that (I) (this hospital) attended the deceased from 6/30 1970 to 7/5 1970 that (I) (we) last saw the deceased alive on 7/5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. Semerdjian M.D.				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Hrant Semerdjian M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL - RRRXX				24B. DATE 7-6-70		24C. NAME OF CEMETERY or CREMATORY NEW YORK	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970				25B. NAME OF REGISTRAR J. E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	
25D. ADDRESS NEW YORK				25E. ADDRESS NEW YORK			

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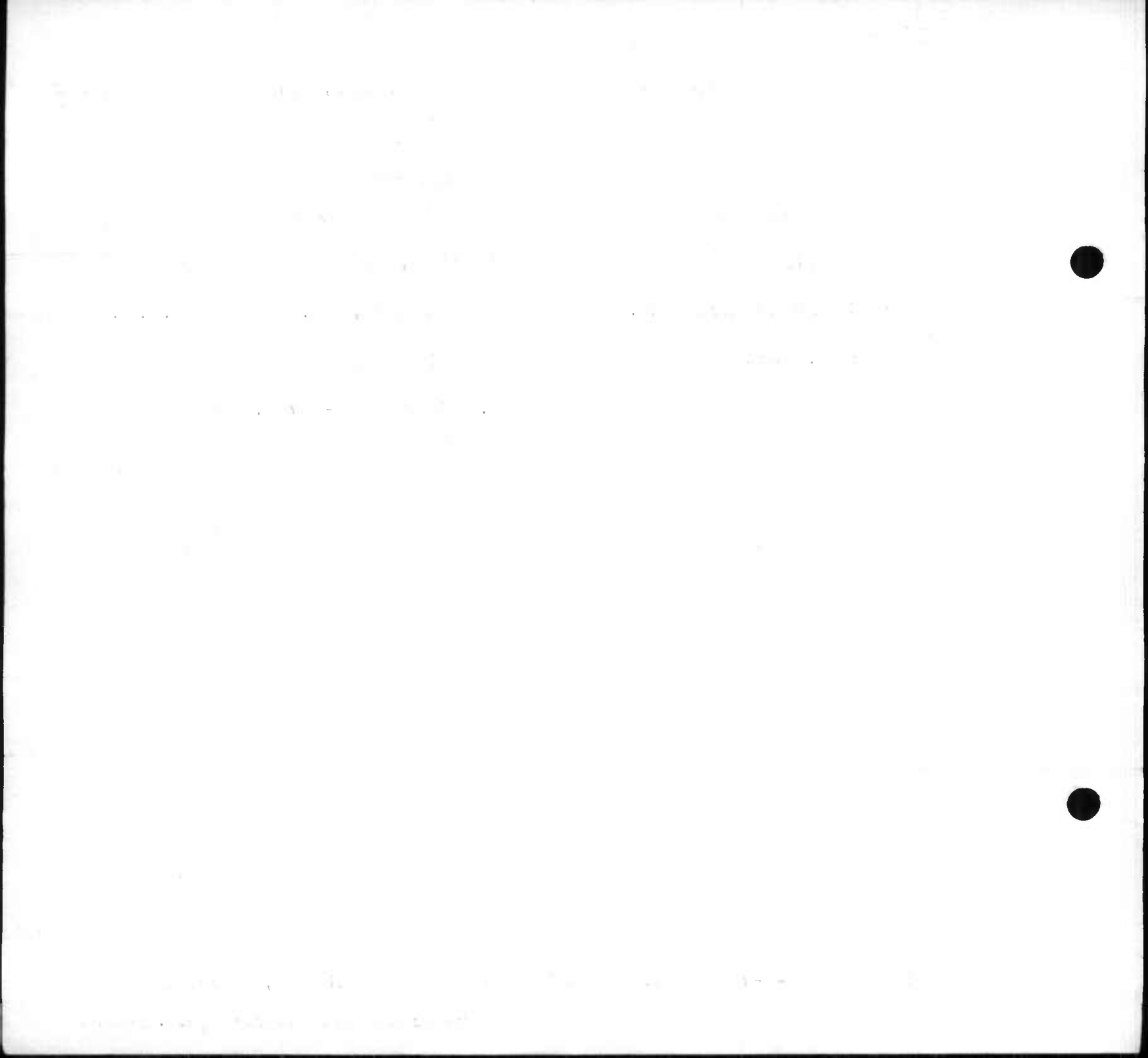
BALTIMORE CITY HEALTH DEPARTMENT		70 6833		REG. NO. 70 6833	
G-526		70 6833		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MAX GINIGER		2. DATE AND HOUR OF DEATH 7/4/70 1:345 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 7 MERCY Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE NEW YORK 8. COUNTY V-29			
FULL NAME OF HOSPITAL OR INSTITUTION 7 MERCY Hospital		C. CITY OR TOWN BROOKLYN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1921 AVENUE K					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17, 1903	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURIER		10B. KIND OF BUSINESS OR INDUSTRY EMPLOYEE FURS		11. BIRTHPLACE (State or foreign country) NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME DAVID GINIGER		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. YES		17. INFORMANT ADDRESS WEST END CHAPEL 4511 FT. Hamilton PKY Brooklyn N.Y.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that we (this hospital) attended the deceased from July 4 1970 to July 4 1970 that we (we) last saw the deceased alive on July 4 1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (and not) view the body after death.					
23A. SIGNATURE Boo Keun Kim		23B. DATE SIGNED July 4, 1970		23C. PHYSICIAN'S NAME (Type) BOO KEUN KIM	
23D. ADDRESS MERCY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL REMOVAL		24B. DATE 7/6/70		24C. NAME OF CEMETERY or CREMATORY MT HEBRON	
24D. LOCATION (City, town, or county) (State) FLUSHING, NEW YORK					
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS 6010 REISTERSTOWN RD.	



FUNERAL DIRECTOR: IMPORTANT

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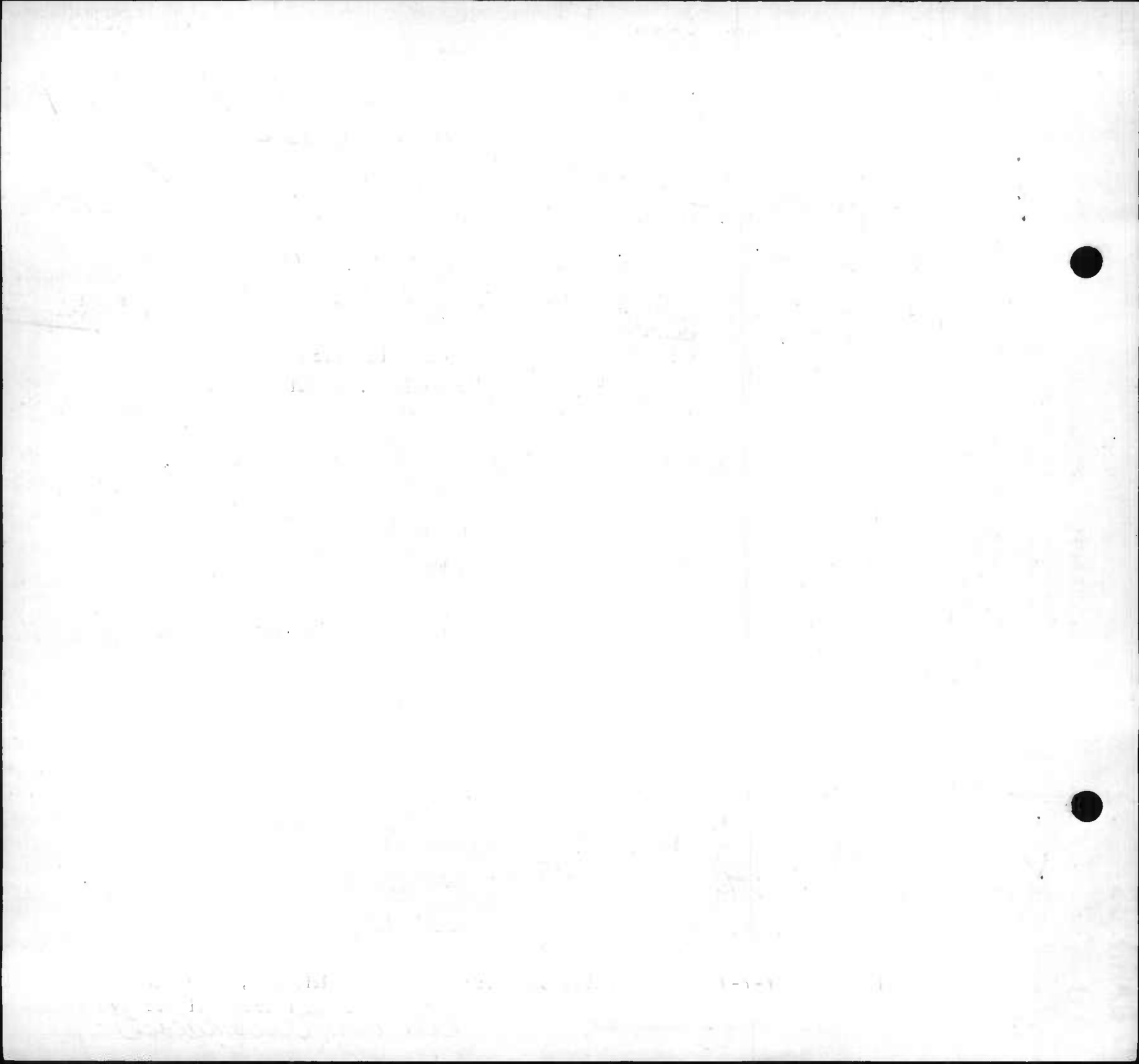
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6834</u>	
BIRTH NO. <u>H-200</u> <u>70 6834</u>					
1. NAME OF DECEASED (Type or Print) <u>Eileen deChantel Haus</u>		2. DATE AND HOUR OF DEATH <u>July 5, 1970</u> <u>9:15 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>70 Long Green Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2841</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3706 Milford Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2, 1904</u>	9. AGE (in years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Revere Copper and Brass Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>John M. Haus</u>		14. MOTHER'S MAIDEN NAME <u>Leidia Downs</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>J. Gilbert Haus-107 E. Belvedere Avenue</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>398 X I 7 230.9</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Rheumatic Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes Mellitus</u> (C) <u>Uremia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>15 yrs.</u> <u>5 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 4 - 19 45</u> to <u>July 5 - 19 70</u> . that (I) was last saw the deceased alive on <u>July 4 - 19 70</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Earl L. Chambers M.D.</u>		23B. DATE SIGNED <u>7/6/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers M.D.</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-8-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE RECEIVED BY HEALTH DEPT. <u>JUL 8 1970</u>		25B. NAME OF REGISTRAR <u>James E. Gabe, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Armacost-4600 Liberty Hghts. Avenue</u>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
M-635 70 6835		CERTIFICATE OF DEATH		70 6835	
1. NAME OF DECEASED (Type or Print) <i>Sarah E. Martin</i>			2. DATE AND HOUR OF DEATH <i>7-4-70 9:00 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balt.</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bolton Hill Nursing & Convalescent Home</i>			C. CITY OR TOWN <i>Balt.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ADDRESS OR LOCATION <i>1400 John St. Balt. Md. 21217</i>			E. STREET AND NUMBER <i>3510 Ingleside Ave 21215</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-18-1908</i>	9. AGE (In years last birthday) <i>70 88X</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cotton Mill</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>James Stoots</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Black</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>225-01-2105</i>		17. INFORMANT <i>Franklin D. Martin Same</i>	
				ADDRESS <i>Admission Record Bolton Hill To Home</i>	
18. <i>599.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Urinary Tract Infection</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>several months</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>several months</i>			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Cerebral Arteriosclerosis</i>			<i>several months</i>		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 9 1970</i> to <i>7. 4. 1970</i> , that (I) (we) lost saw the deceased alive on <i>7. 5. 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>E. Ellsworth Cook M.D.</i>				23B. DATE SIGNED <i>7.5.70</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. Ellsworth Cook M.D.</i>				23D. ADDRESS <i>2431 Maryland Ave Balt. Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-7-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Lorraine Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 8 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fairley</i>		25C. FUNERAL DIRECTOR <i>Ellsworth Cremacast</i>	
				ADDRESS <i>4600 Liberty Heights Ave</i>	



FUNERAL DIRECTOR: IMPORTANT

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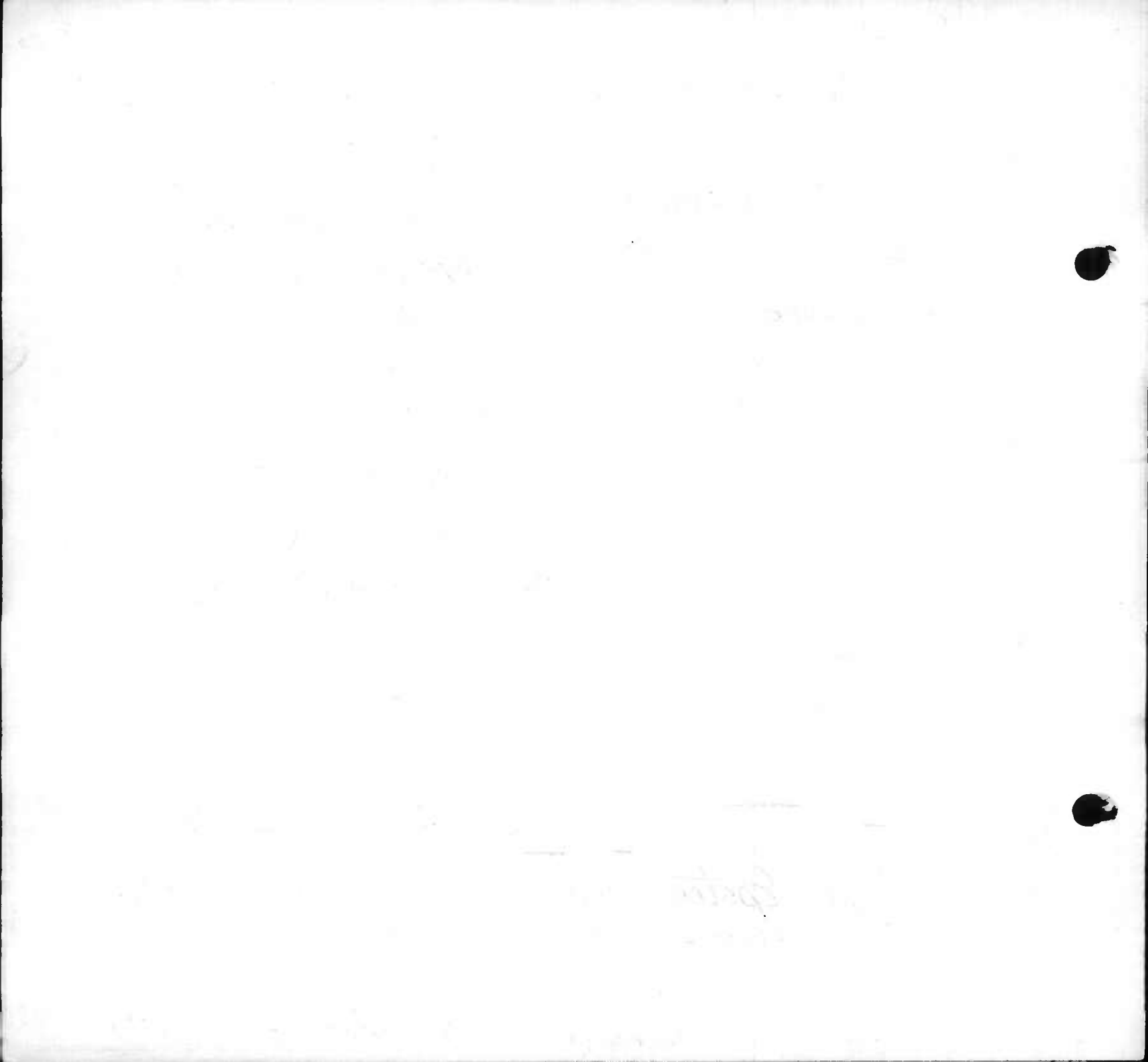
C-524 70 6836		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6836
BIRTH NO.		1. NAME OF DECEASED (Type or Print) COUNCELL MAUDE		2. DATE AND HOUR OF DEATH 7/1/70 4:30 A.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION Granada Nursing Home 4017 Liberty Hgts Ave		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-15-83 9. AGE (In years last birthday) 86		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md
13. FATHER'S NAME James A. Council		14. MOTHER'S MAIDEN NAME Carrie Frozier		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Granada Nursing Homes 4017 Liberty Hgts
18. 4-21-70 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL HEMORRHAGE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3/18/40 19 to 7/1/70 19 that (I) (we) last saw the deceased alive on 7/1/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE HOLLIS SEUNARINE		23B. DATE SIGNED 7/1/70		23C. PHYSICIAN'S NAME (Type) HOLLIS SEUNARINE
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7-2-70		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT JUL 8 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Armstrong Funeral Chapel		

Amphibian & Reptile Society

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

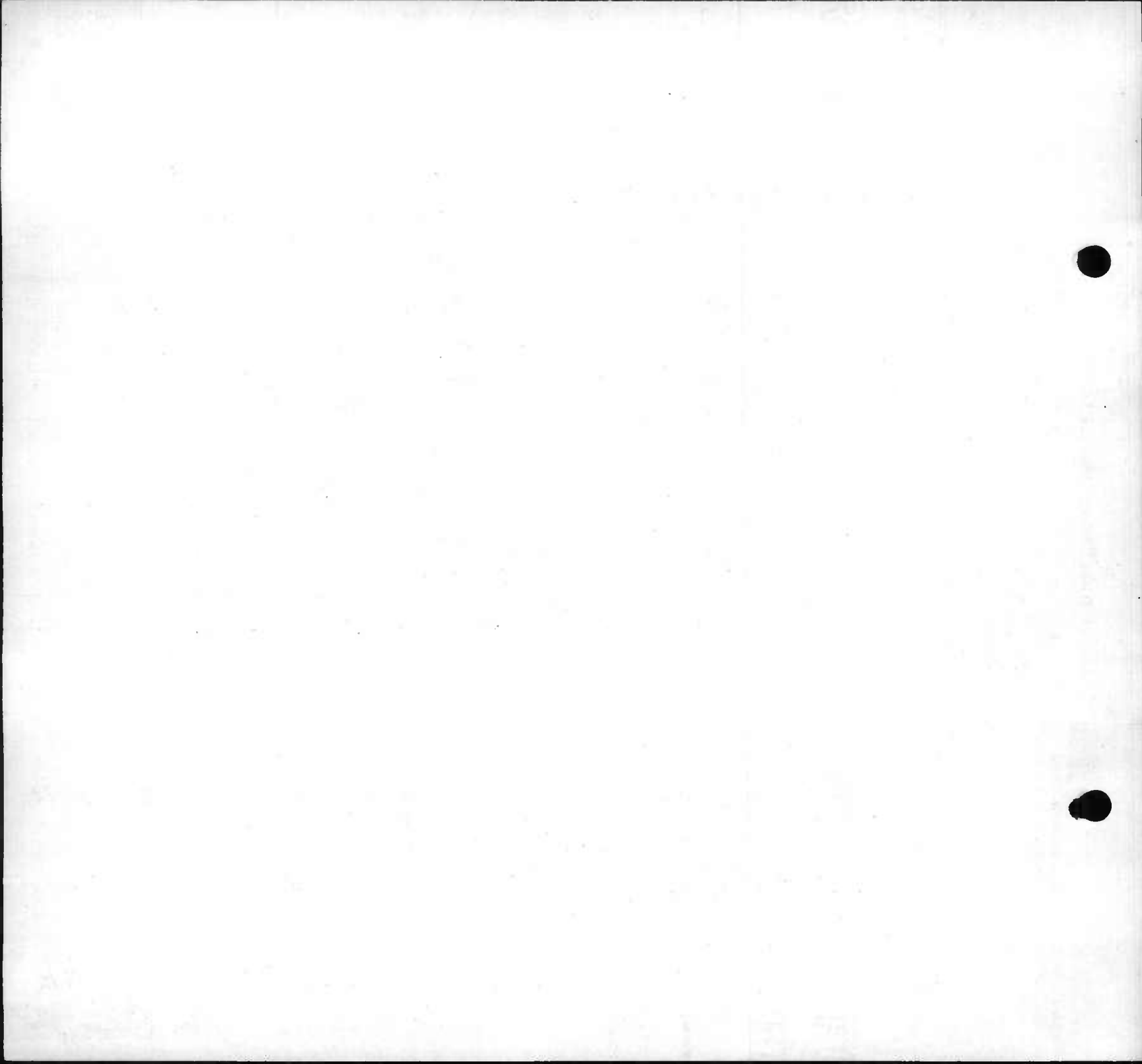
S-620 70 6837		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6837	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WETTA SUROSKY		2. DATE AND HOUR OF DEATH 7/6/70 6²⁵ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2730		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6414 ELIZAY DR.		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/99	9. AGE (In years last birthday) 70
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Solomon			14. MOTHER'S MAIDEN NAME Ida		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Albert Surosky	
				ADDRESS Some	
18. 4/10/91-25017 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF: (B) Acute Myocardial Infarction and DUE TO, OR AS A CONSEQUENCE OF: (C) ASVD Diabetes Mellitus		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (was) attended the deceased from June 17 1970 to July 6 1970 that (I) (was) last saw the deceased alive on July 6 1970 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.					
23A. SIGNATURE Ralph Epstein M.D.			23B. DATE SIGNED 7/6/70		23C. PHYSICIAN'S NAME (Type) RALPH EPSTEIN M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/8/70		24C. NAME OF CEMETERY or CREMATORY Workmen Circle
24D. LOCATION (City, town, or county) (State) Balto Md			25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		
25B. NAME OF REGISTRAR Robert E. Fisher, R.D.			25C. FUNERAL DIRECTOR Sylvan Lewis & Son 9616 Reisterstown Rd		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

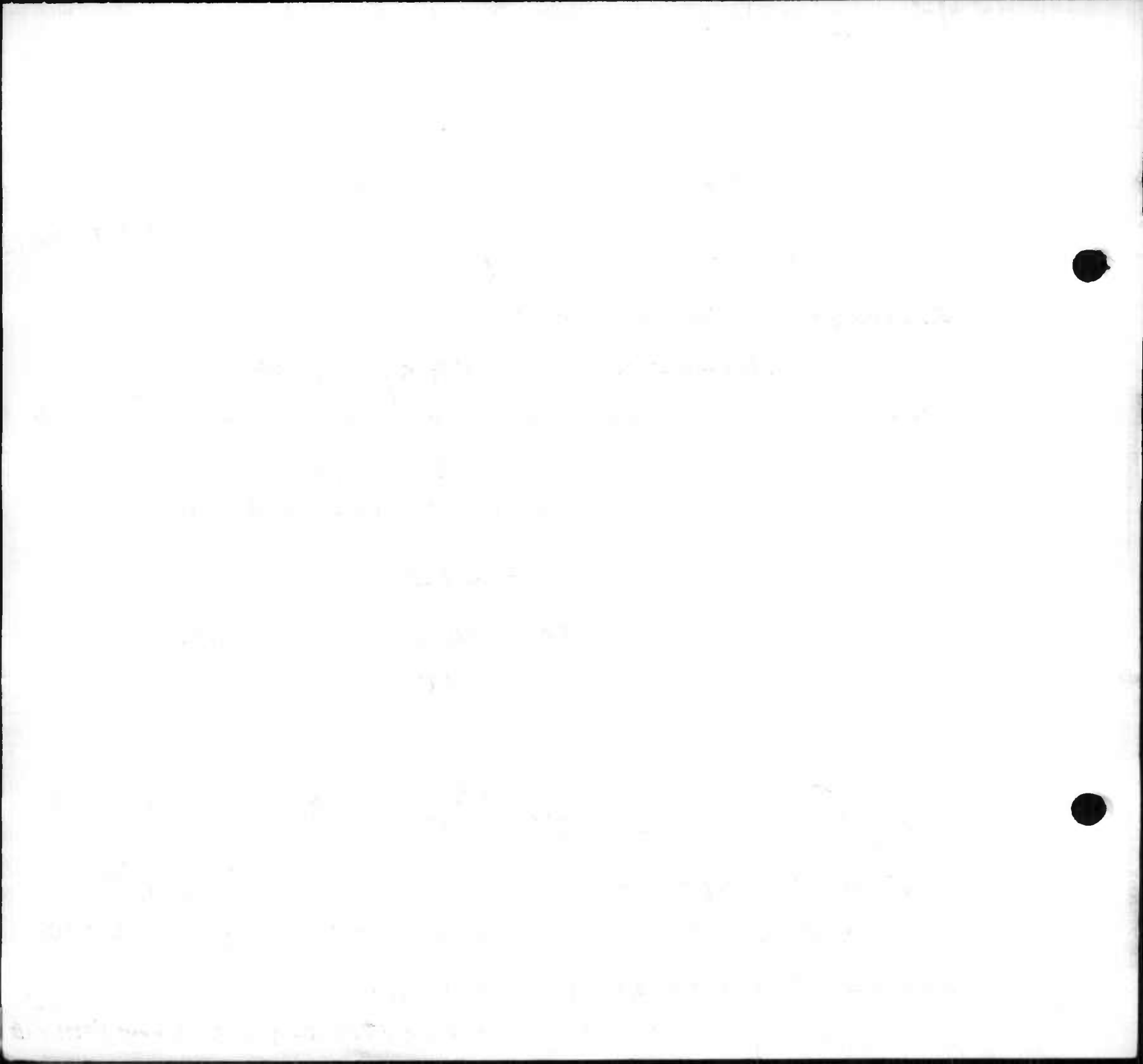
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6838	
S-620 70 6838				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Schwarz, Siegfried</u>		2. DATE AND HOUR OF DEATH <u>7-7-70</u> <u>3</u> ²⁰ <u>A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2717</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles General Hospital</u>		E. STREET AND NUMBER <u>5005 Chalmers Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/03</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Isaac Schwarz</u>		14. MOTHER'S MAIDEN NAME <u>Selma Gideon</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-3201</u>		17. INFORMANT <u>NCG.H. chart.</u>	
18. <u>20791</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardio respiratory failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Leukemia, terminal</u> <u>Stage</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Possible myocardial infarction</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>7-3</u> 19 <u>70</u> to <u>7-7</u> 19 <u>70</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>7-7</u> 19 <u>70</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (<u>did not</u>) view the body after death.			
23A. SIGNATURE <u>Frank F. Foy</u>		23B. DATE SIGNED <u>7/7/70</u>		23C. PHYSICIAN'S NAME (Type) <u>MATYAS RELKE MD</u>	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/8/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Cherry Chapel</u>		24D. LOCATION (City, town, or county) (State) <u>Randallstown Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1970</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Ed Van Lewis</u>		25D. ADDRESS <u>Ed Van Lewis, Md</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

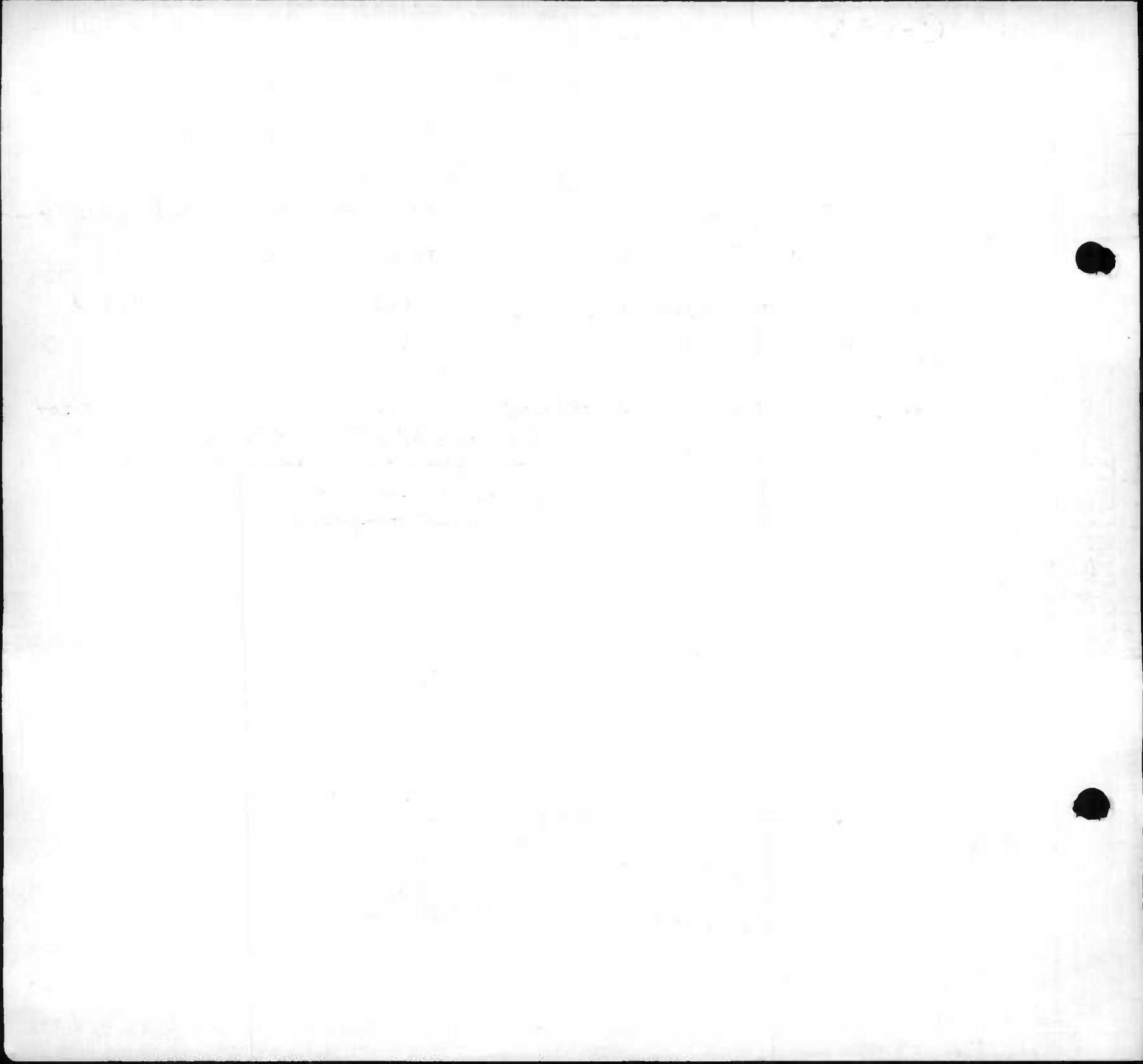
M-460 70 6839		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6839	
1. NAME OF DECEASED (Type or Print) JOSEPH P. MILLER		2. DATE AND HOUR OF DEATH 7/4/70 1 15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 44		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2814 LINWOOD AVE 21234			
5. SEX M	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/94	9. AGE (In years last birthday) 75	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY GAS + ELECTRIC CO		11. BIRTHPLACE (State or foreign country) MD	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME JOSEPH MILLER		14. MOTHER'S MAIDEN NAME MARY BRAUN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-05-7310		17. INFORMANT JOSEPH G. MILLER ADDRESS 3001 LAVENDER AVE. 21234	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCTION (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CARDIAC OBSTRUCTIVE PULMONARY DISEASE					
19A. DATE OF OPERATION 7/4/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 7/4 19 70 to 7/4 19 70 and that (2) (we) last saw the deceased alive on 7/4 19 70 and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.)					
23A. SIGNATURE Ronald M. Legum		23B. DATE SIGNED 7/4/70		23C. PHYSICIAN'S NAME (Type) RONALD M. LEGUM M.D.	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 6-70		24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY PARKVILLE BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR LASSAUN FUNERAL HOME 740 BELAIR RD ADDRESS 21236	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

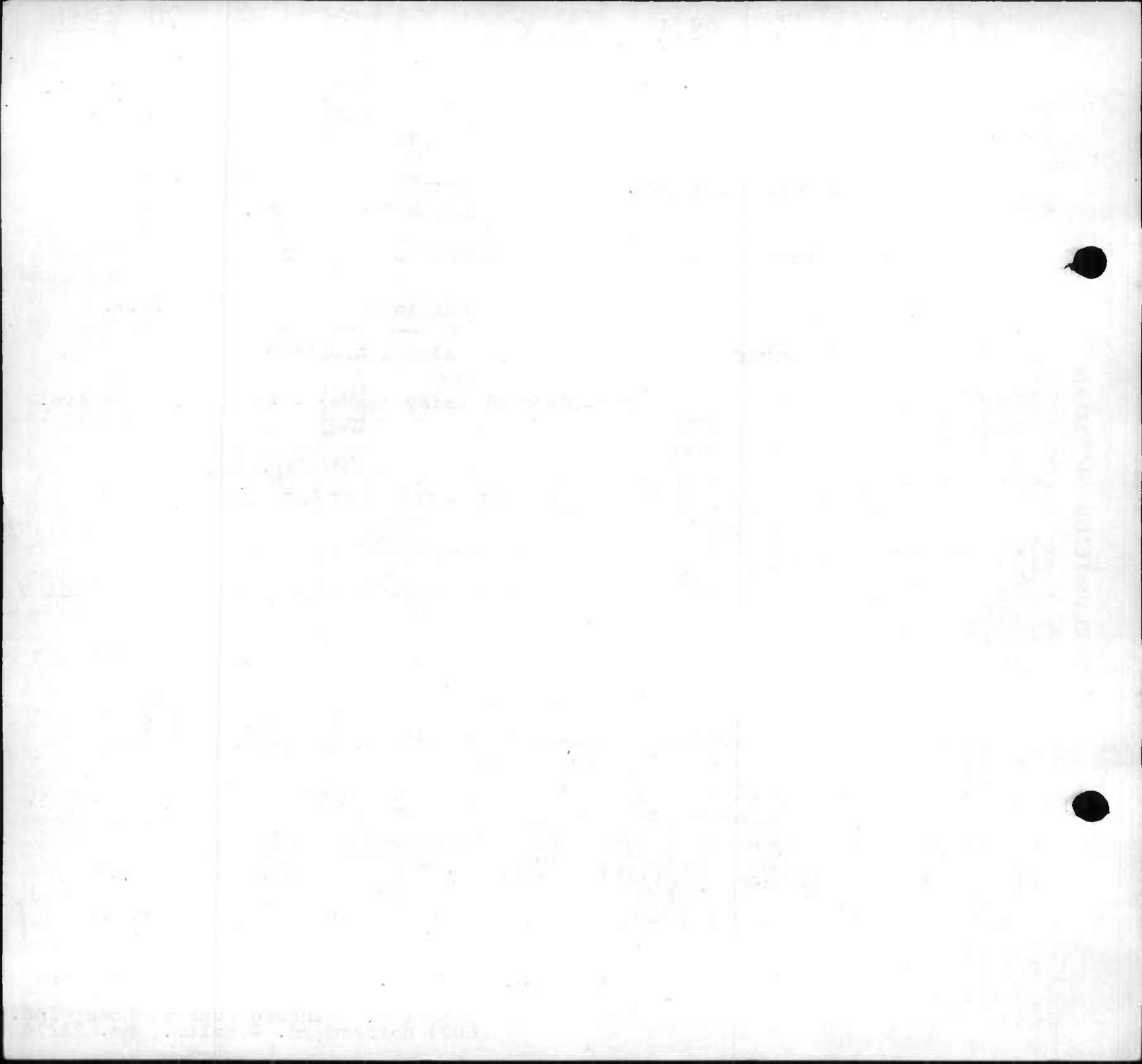
BIRTH NO. C-652		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 6840	
M.E. CASE NO. 70 6840		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIAM H CRANSTON		2. DATE AND HOUR OF DEATH 7/2/1970 8:40 AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1/8 Maryland Gen. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1612 Providence Rd. 21204			
5. SEX M.	6. RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 6/16/1915	9. AGE (In years last birthday) 55	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Operator		10B. KIND OF BUSINESS OR INDUSTRY WEBER MOVING & STORAGE		11. BIRTHPLACE (State or foreign country) md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Aguilla Amos Cranston		14. MOTHER'S MAIDEN NAME Julia Kaline	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO YES WW II		16. SOCIAL SECURITY NO. 220-03-2917		17. INFORMANT ROBERT CRANSTON 22 TERRON CT. 21204	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PULMONARY CONGESTION LYMPHATIC SARCOMA, widespread		CAUSE OF DEATH (A) DUE TO malignant metastasis (B) DUE TO Adenocarcinoma lymphatic (C) _____		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/25/1970 to 7/2/1970 and that (I) (we) last saw the deceased alive on 7/2/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M.S. Al-Ibrahim M.D.				23B. DATE SIGNED 7/2/1970	
23C. PHYSICIAN'S NAME (Type) M.S. AL-IBRAHIM M.D.				23D. ADDRESS md. Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE JULY 6-70		24C. NAME of CEMETERY or CREMATORY PROVIDENCE UNITED MET. CH. CEM. TOWSON	
24D. LOCATION (City, town, or county) BALTO.		(State) MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Lassan Funeral Home 7401 BELAIR RD. 21236		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

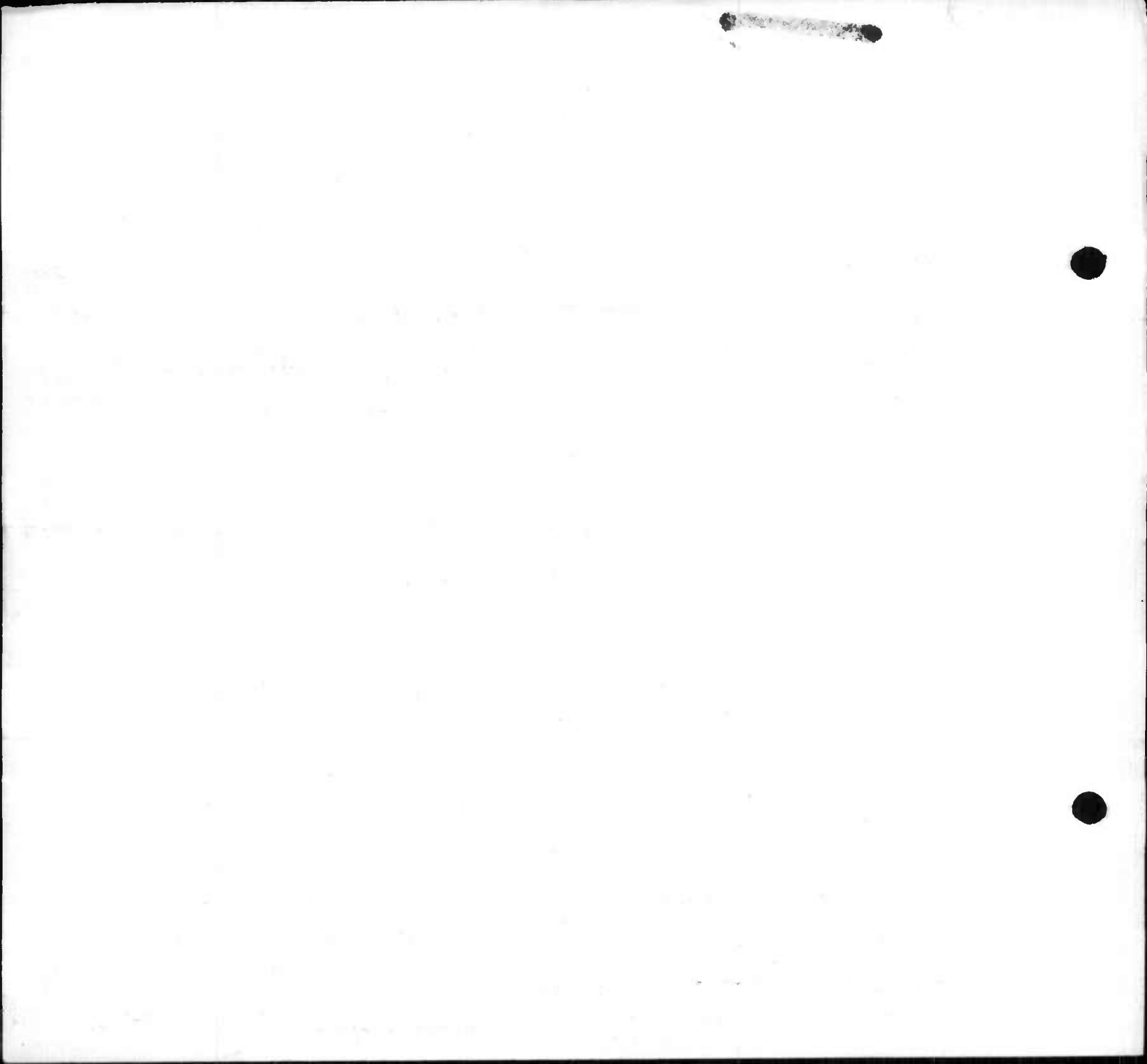
BIRTH NO. <u>W-160 70 6841</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 6841</u>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Ernest G. Weaver				7/3/70 7:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 4311 Willshire Ave.				Maryland			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				4311 Willshire Ave.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		1/2/1898	72		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Chauffeur						Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Gideon Weaver				Almira Armstrong		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WWI				212-01-6215A		Daisy Weaver - 4311 Willshire Ave.	
18. 157.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA PANCREAS With HEPATIC METASTASIS				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION (s).				II Ileo-femoral Thrombosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-12-1970 to 7-2-1970 , that (I) (we) last saw the deceased alive on 7-2-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sebastian Russo				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7-3-70	
23C. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO MD				23D. ADDRESS 5017 Harford Rd Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		7/8/70		Baltimore National Cem.		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 8 1970		Robert C. Albemur		Robert C. Albemur		Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

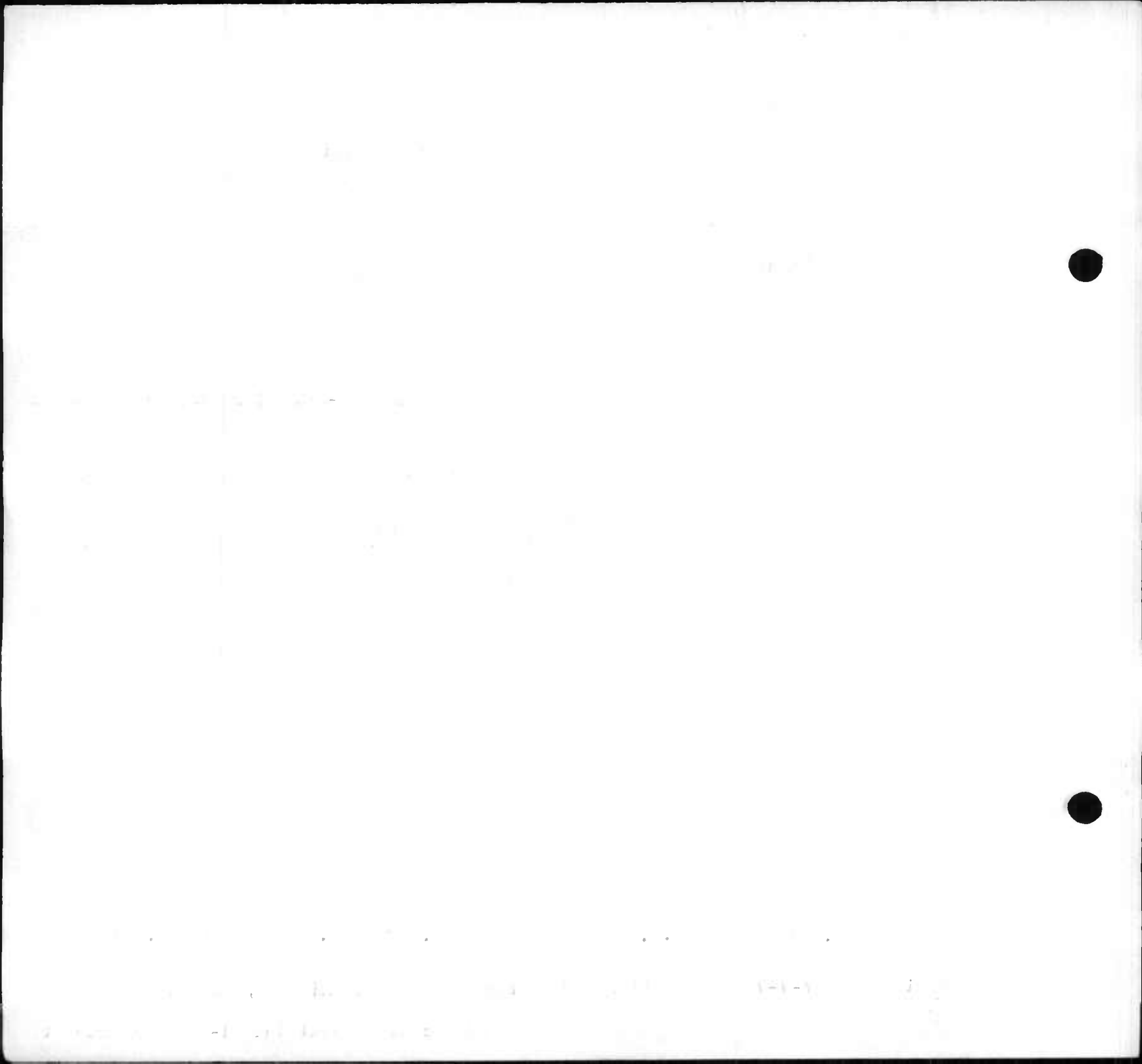
BALTIMORE CITY HEALTH DEPARTMENT				X	
BIRTH NO. <u>70-11166</u> <u>70</u> <u>6842</u> CERTIFICATE OF DEATH				REG. NO. <u>70</u> <u>6842</u> <u>4</u>	
1. NAME OF DECEASED (Type or Print) <u>Zlotak, Baby boy</u>			2. DATE AND HOUR OF DEATH <u>7-5-70</u> <u>9:20 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital of Baltimore</u> <u>42</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>8011 Woodgate Ct. #07</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-70</u>	9. AGE (In years last birthday) <u>21</u> <u>30</u>	10. Under 1 Yr. Months: Days: <u>21</u> <u>30</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Ernest Zlotak</u>			14. MOTHER'S MAIDEN NAME <u>Beverly Weinberg</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u></u>		
17. INFORMANT <u>Beverly Zlotak</u>			ADDRESS <u>8011 Woodgate Ct Baltimore</u>		
18. <u>776.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio-Respiratory Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Respiratory Distress Syndrome</u> <u>Pre-maturity</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>21 1/2 hours</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>					
19A. DATE OF OPERATION <u>None</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u></u>	
21D. TIME OF INJURY (APPROX.) <u></u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u></u>	
22. I certify that (I) (the hospital) attended the deceased from <u>7-4-70</u> 19 <u>70</u> to <u>7-5</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7-5</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louise M. Lisi M.D.</u>				23B. DATE SIGNED <u>7-5-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Louise M. Lisi M.D.</u>				23D. ADDRESS <u>Sinai Hospital of Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/6/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sharon Zion</u>	
24D. LOCATION <u>Balt</u>		24E. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>		24F. FUNERAL DIRECTOR <u>Sylvan Zlotak Son</u>	
24G. ADDRESS <u>9610 Ruston Rd</u>		24H. ADDRESS <u>9610 Ruston Rd</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

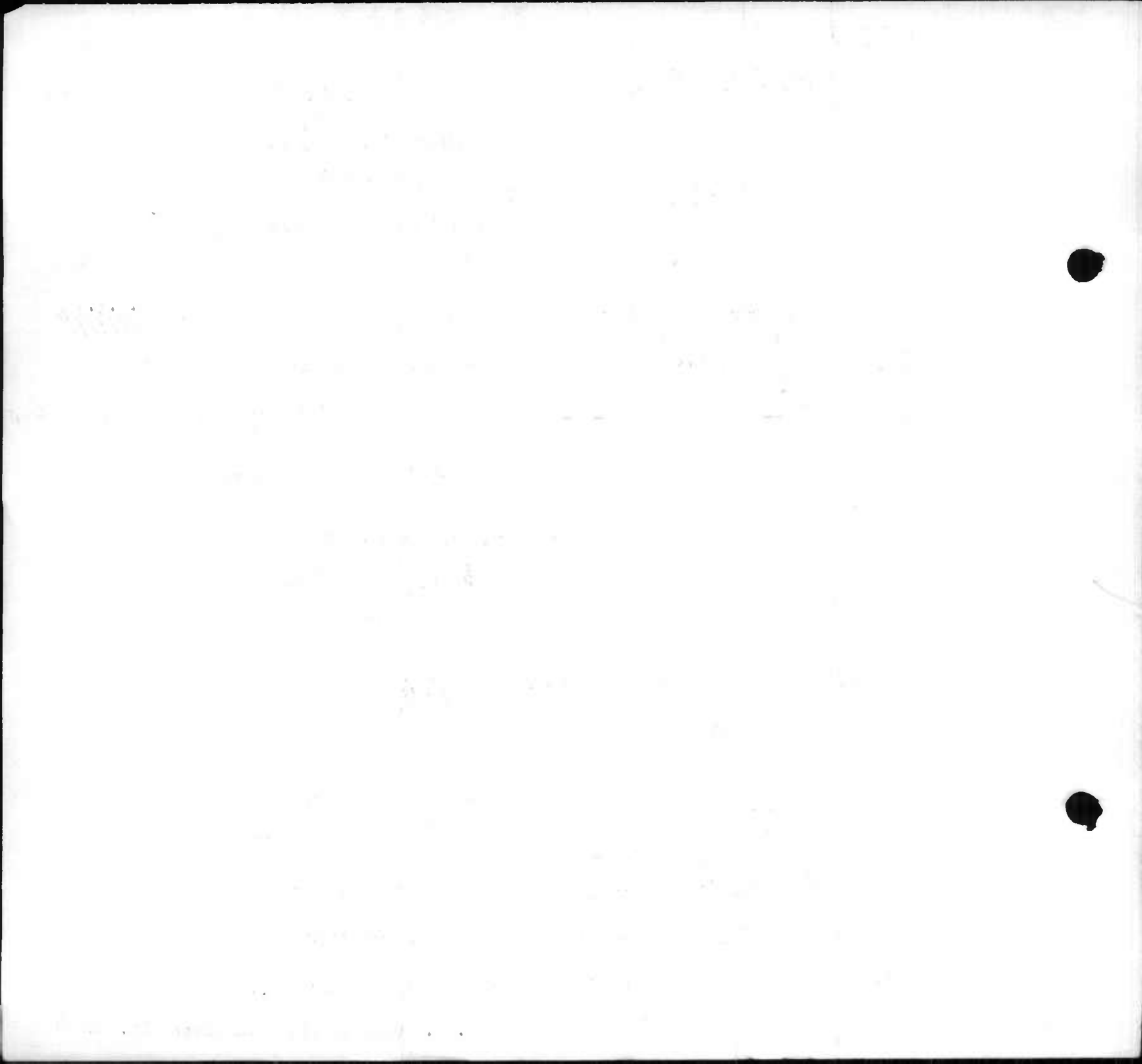
S-142 70 6843		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6843	
BIRTH NO.		CERTIFICATE OF DEATH		A. M.	
1. NAME OF DECEASED (Type or Print) <u>Edith T Spelissy</u>		2. DATE AND HOUR OF DEATH <u>7/4/70</u> <u>1330</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Keswick Baltimore md 700 W 40th St</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5000 Cordelia Ave</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-95</u>	9. AGE (In years last birthday) <u>74</u>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore md</u>	
13. FATHER'S NAME <u>Frank Tilghman</u>		14. MOTHER'S MAIDEN NAME <u>Elmira Seymour</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214 405484</u>		17. INFORMANT ADDRESS <u>Thelda Strunge-5000 Cordelia Avenue 21215 Keswick Medical Records</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Thrombosis</u> (B) <u>Hypertensive Cardiovascular Dis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Osteoarthritis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>12 yrs</u> <u>12 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7/3/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9 Sept 1968</u> to <u>3 July 1970</u> that (I) (we) lost saw the deceased alive on <u>3 July 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Aubrey D. Richardson M.D.</u>		23B. DATE SIGNED <u>3 July 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-7-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Armacost Funeral Chapel-4600 Liberty Hts</u>	



FUNERAL DIRECTOR: IMPORTANT

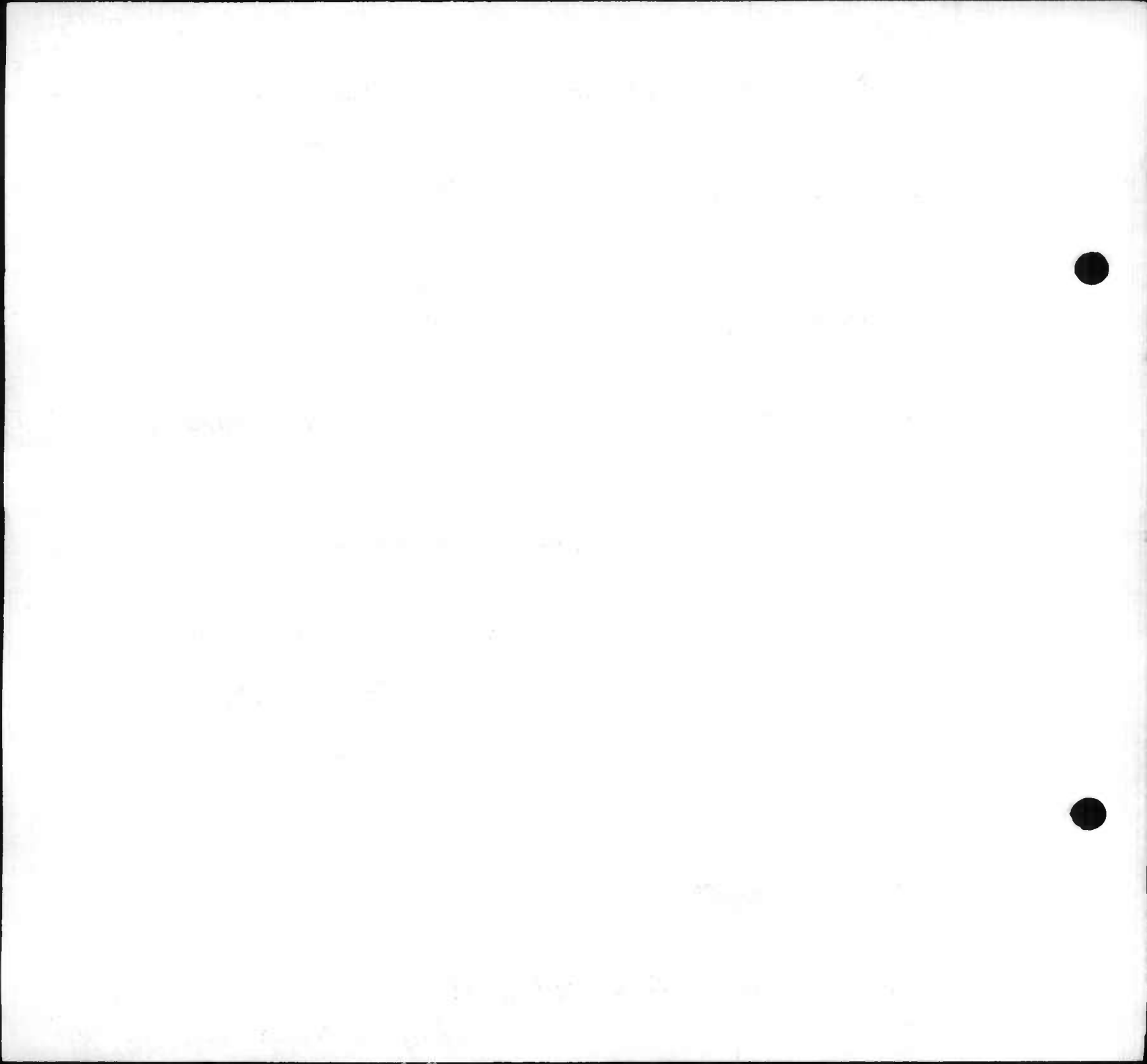
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-520		70 6844		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6844	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Enrico Lanci				2. DATE AND HOUR OF DEATH 7/3/70 10:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION Memorial Hospital						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Baltimore Maryland 5300 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1417 Patty Hill Ave.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/17/95	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Presser				10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Lanci				14. MOTHER'S MAIDEN NAME ROSE ANARNARELLO					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-09-5614		17. INFORMANT Wife & SON → 102 Springview Court			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 6/22/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 1st OK 2nd bad. 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (A) IMMEDIATE CAUSE Massive hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Bleeding gallbladder bed DUE TO, OR AS A CONSEQUENCE OF: (C) post. cholecystectomy APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 6/22/70 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 1st OK 2nd bad. 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 6/22 1970 to 7/3 1970 that (I) (we) last saw the deceased alive on 7/3 1970 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE H. D. 23B. DATE SIGNED 7/3/70 23C. PHYSICIAN'S NAME (Type) CARLOS E. Fossi 23D. ADDRESS UNION Memorial Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 7/06/1970 24C. NAME of CEMETERY or CREMATORY Meadow Ridge Memorial Park 24D. LOCATION (City, town, or county) (State) Howard Co., Maryland 25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970 25B. NAME OF REGISTRAR Robert E. Hagen 25C. FUNERAL DIRECTOR Wm. E. Johnson 25D. ADDRESS 8521 Loch Raven Blv. 21204									



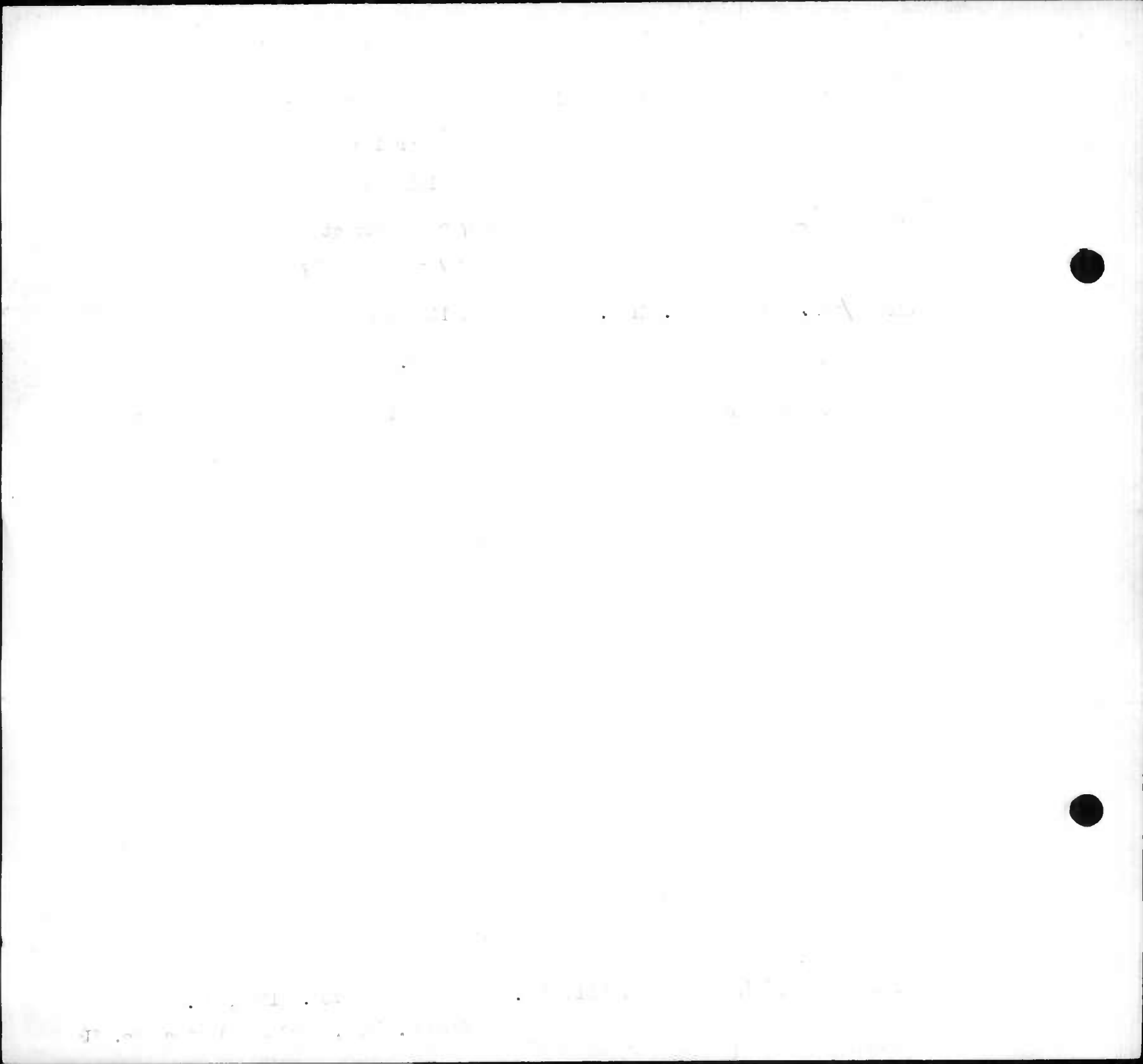
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-325		70 6845		BALTIMORE CITY HEALTH DEPARTMENT		X		70 6845	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MR. WILLIAM H. FITZSIMMONS		2. DATE AND HOUR OF DEATH JULY 4, 1970		5:30 am		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Sykesville C. CITY OR TOWN Sykesville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3 BOX 172-D Dogwood.					
5. SEX Male		6. RACE White American		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/1900		9. AGE (In years last birthday) 69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cable Splicer				10B. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Fitzsimmons				14. MOTHER'S MAIDEN NAME Elizabeth Woodrow					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-0730		17. INFORMANT Tatsy Fitzsimmons Adams - Ramsey, N.J.					
18. 371.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty liver & cirrhosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Chr. alcoholism (C) Bilat. confl. bronchopneumonia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 years					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Bilat. confl. bronchopneumonia									
19A. DATE OF OPERATION 7-7-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21C. WHERE DID INJURY OCCUR? No		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -					
22. I certify that (I) (this hospital) attended the deceased from 6-23 1970 to 7-4 1970 that (I) (we) last saw the deceased alive on 7-3 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Kusuma Pruksapong				DEGREE MD		23B. DATE SIGNED 7/4/1970		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) DR. KUSUMA K. PRUKSAPONG				23D. ADDRESS BON SECOURS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-70		24C. NAME OF CEMETERY OR CREMATORY Landon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

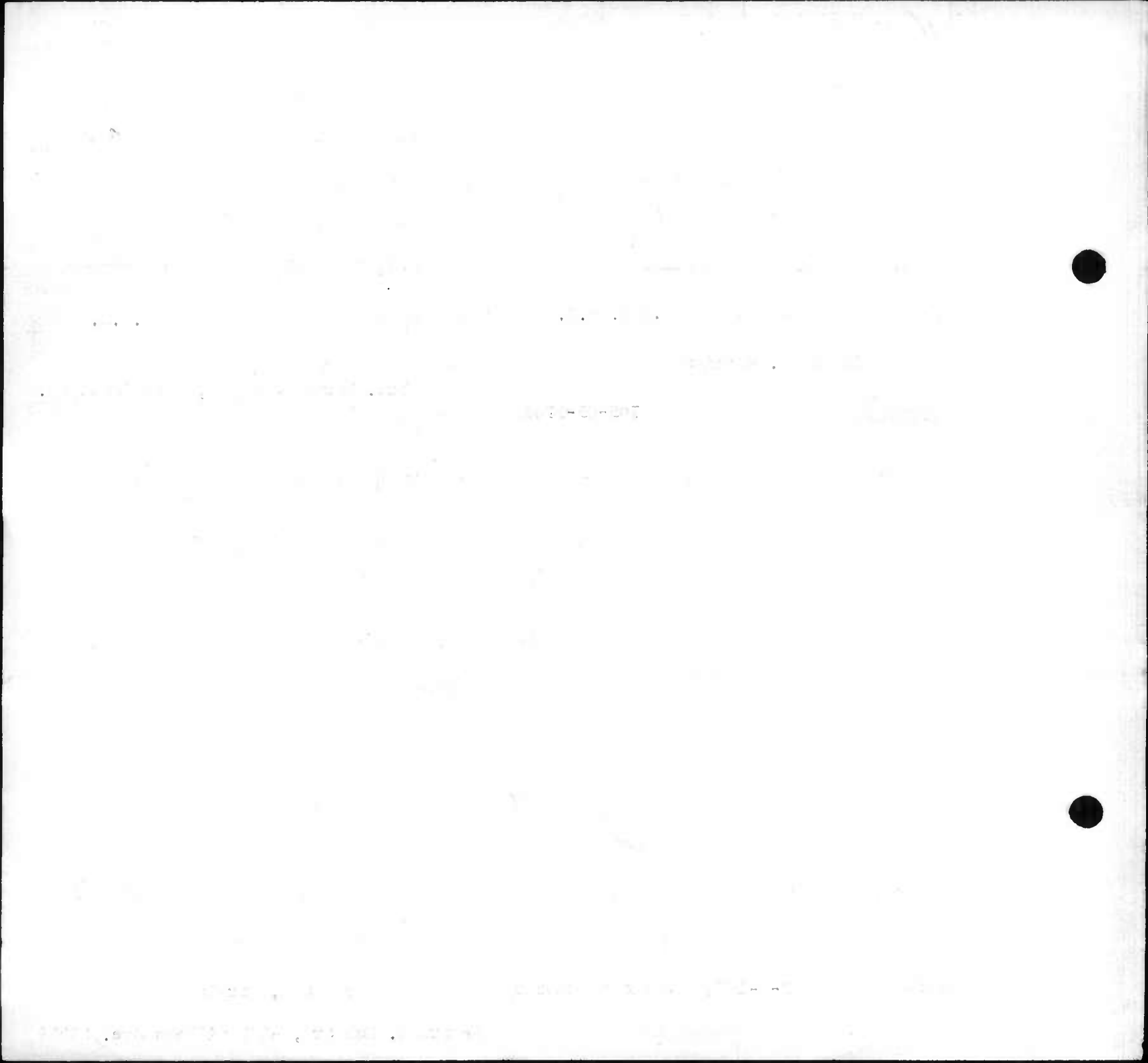
V-520		70 6846		BALTIMORE CITY HEALTH DEPARTMENT		70 6846	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) Edward Adolph Young				2. DATE AND HOUR OF DEATH 7-6-70 11:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2506			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3702 Lee Street			
5. SEX M	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/5/03	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Ass. Lnenan		10B. KIND OF BUSINESS OR INDUSTRY Gen. Elec.		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Coast Guard		16. SOCIAL SECURITY NO.		17. INFORMANT Family		ADDRESS Same	
18. 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic Coronary Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kermit J. Bonovich				23B. DATE SIGNED 7-6-70			
23C. PHYSICIAN'S NAME (Type) Kermit J. Bonovich M.D.				23D. ADDRESS 1916 Belair Rd. Fallston 21047, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/70		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cem.		24D. LOCATION (City, town, or county) (State) Balto. 21225, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John M. Hahn		ADDRESS 4200 Pennington Ave. 24	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

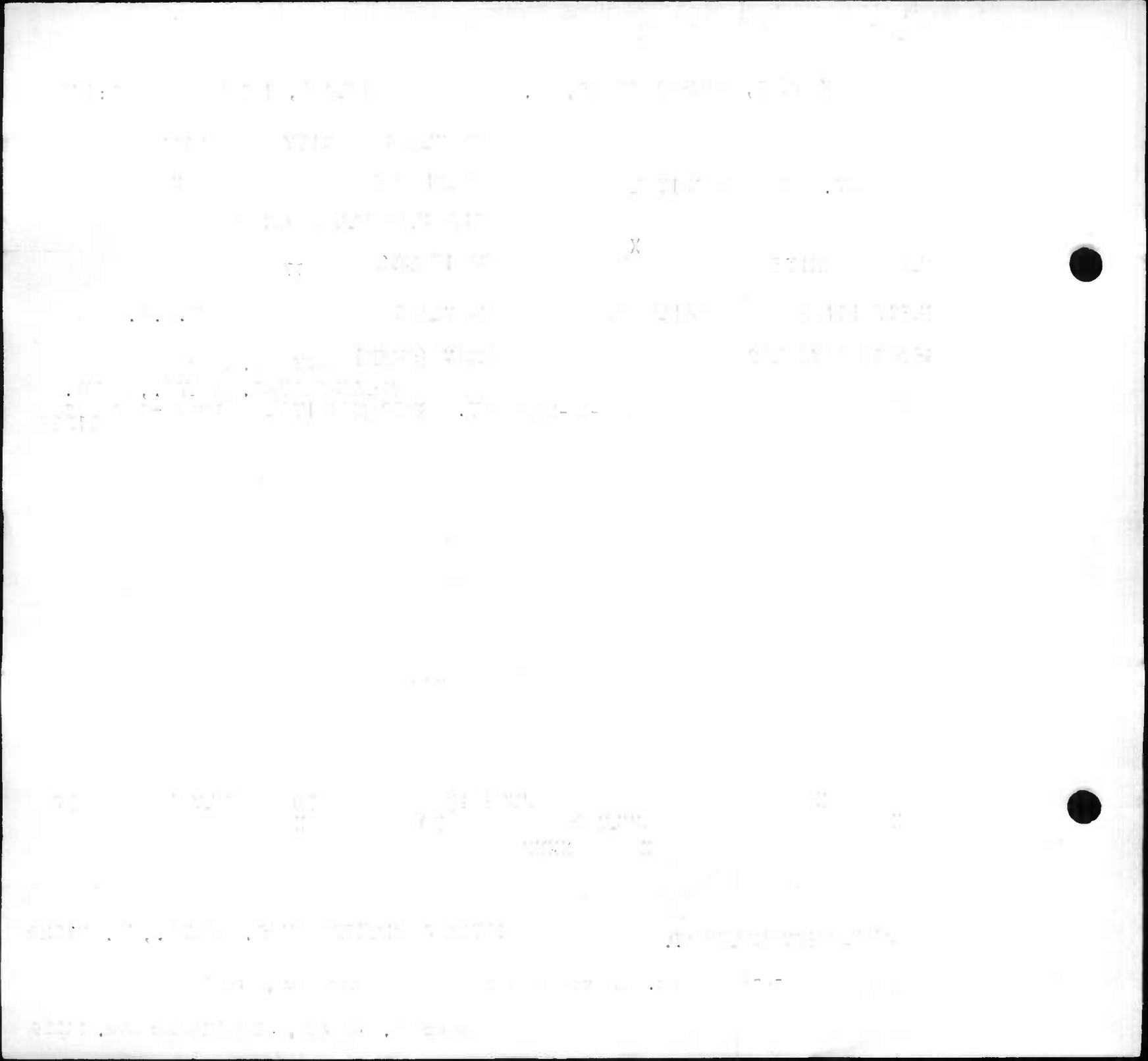
H-525 70 6847		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6847	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) HANNIGAN, CHARLES SR.			2. DATE AND HOUR OF DEATH 7-4-70 10:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore Gen. Hosp. 3001 S. Hanover St			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2102		
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6-23-85 9. AGE (In years last birthday) 85		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Worker			11. BIRTHPLACE (State or foreign country) Pennsylvania		
10B. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William R. Hannigan			14. MOTHER'S MAIDEN NAME Fannie Snyder		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 705-05-3749		
17. INFORMANT Mrs. Marie Hannigan, 1334 James St. 21223			18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary edema, congestive		
			(B) Coronary sclerosis + heart fibrosis DUE TO, OR AS A CONSEQUENCE OF:		
			(C) Generalized arteriosclerosis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pancytopenia			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-19 19 70 to 7-4 19 70 that (I) (we) last saw the deceased alive on 7-4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Victor Albites M.D.			23B. DATE SIGNED 7-4-70		23C. PHYSICIAN'S NAME (Type) VICTOR ALBITES
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 7-8-1970		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery
24D. LOCATION Woodlawn, Maryland			25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

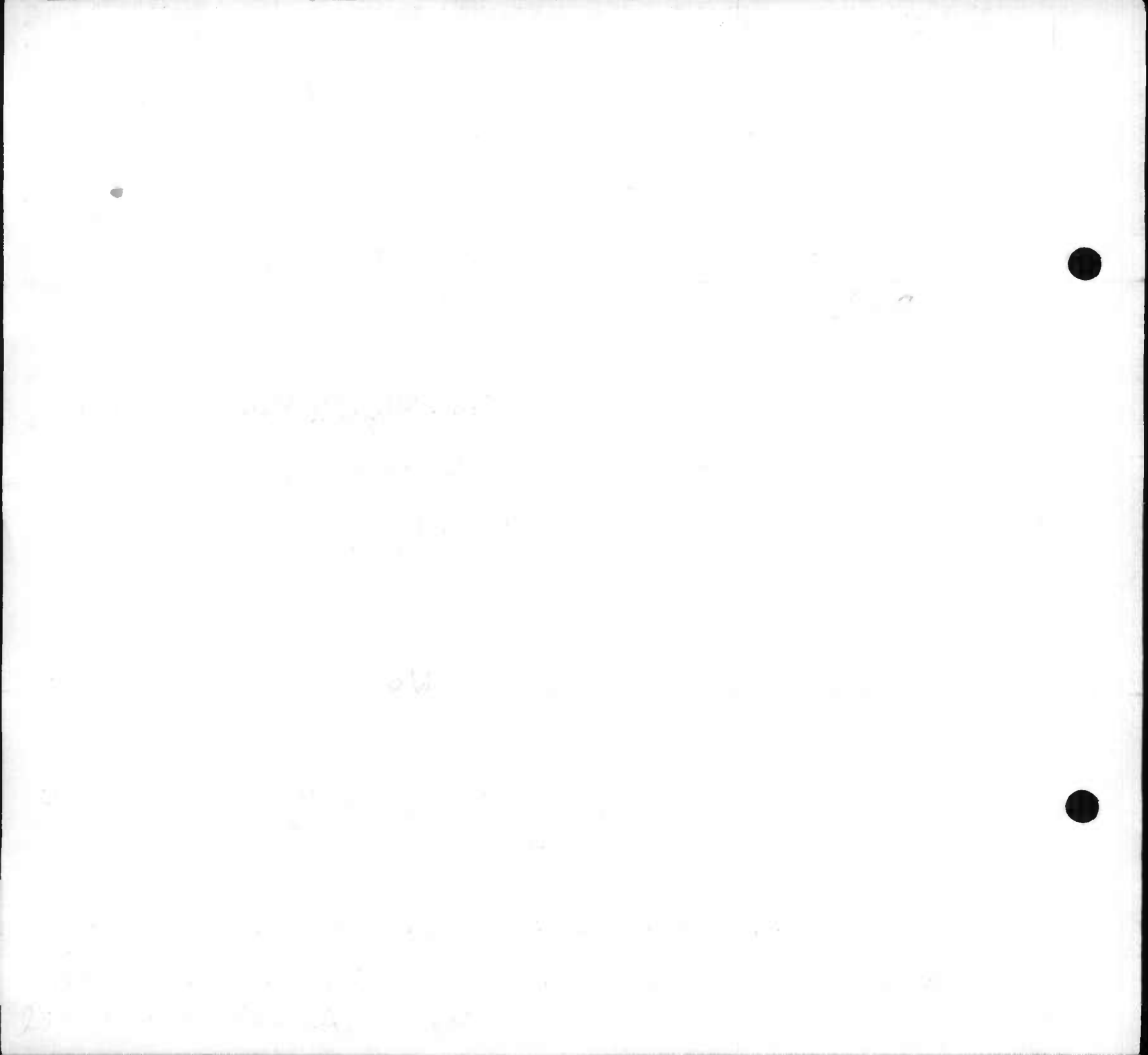
BIRTH NO. R-543		70 6848		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6848	
1. NAME OF DECEASED (Type or Print) REYNOLDS, EDWARD JAMES, SR.				2. DATE AND HOUR OF DEATH JULY 4, 1970 2:15P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY CITY 21229 1834 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 516 GLEN ALLEN DRIVE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09 16 1892	9. AGE (In years last birthday) 77	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN			10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE REYNOLDS			14. MOTHER'S MAIDEN NAME MARY A. JUBB				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 705-10-2460		17. INFORMANT WILKENS AVES. BALTO, MD. ST. AGNES HOSPITAL RECORDS-CATON, 21229		
18. 412.4 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Small bowel obstruction 17 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pneumonia + Septicemia ASCVD - Chronic Brain Ischemia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Inotify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 17 19 70 to JULY 4 19 70 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 4 19 70 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
23A. SIGNATURE Paul Westphalen				23B. DATE SIGNED July 5, 1970		23C. PHYSICIAN'S NAME (Type) PAUL WESTPHALEN MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-1970		24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-200		BALTIMORE CITY HEALTH DEPARTMENT		X	
70 6849		CERTIFICATE OF DEATH		REG. NO. 70 6849	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH FOX		2. DATE AND HOUR OF DEATH 7/4/70 11:05 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SINAI HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 BALTO. MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 8004 WOODGATE ST. APT. #67	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/30/92	9. AGE (in years last birthday) 77	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) AUSTRIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Elizabeth Fox	
18. 410.9 + 1 230.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Diabets mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (he) (this hospital) attended the deceased from 6/29 19 70 to 7/4 19 70 that (he) (we) last saw the deceased alive on 7/4 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Fortunato V. Eliza		23B. DATE SIGNED 7/4/70		23C. PHYSICIAN'S NAME (Type) FORTUNATO V. ELIZAGA	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/6/70		24C. NAME OF CEMETERY or CREMATORY Clermont Avenue Chesed	
24D. LOCATION Randallstown Md		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Sylvan Lewis & Son 9610 Quakerstown Rd		25D. ADDRESS		25E. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 6850	
BIRTH NO. K-640 70 6850		1. NAME OF DECEASED (Type or Print) Helen M. Kral			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSP 44		2. DATE AND HOUR OF DEATH July 5, 1970 10:50 PM. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2534 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 406 Frankie St.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-12-13		9. AGE (In years last birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Secretary		10B. KIND OF BUSINESS OR INDUSTRY Kramer Electronics		11. BIRTHPLACE (State or foreign country) Penn. Balt. Md.	
13. FATHER'S NAME Unknown William Charvat		14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 213-09-8236		17. INFORMANT Joseph V. Kral - came as #4 ADDRESS	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> (A) IMMEDIATE CAUSE Carcinoma of Pancreas DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-650 70 6851		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO. 70-11269		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Michelle Marie KORONA, BABY GIRL "B"		JULY 4, 1970 11:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		MARYLAND BALTIMORE 530021227	
5. SEX 6. RACE		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
FEMALE WHITE		BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER	
8. DATE OF BIRTH 9. AGE (In years last birthday)		1253 STEVENS AVENUE	
06/29/70			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
INFANT		MARYLAND- Baltimore	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
---		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JAMES KORONA		SHEILA CONELIUS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No --		None	
17. INFORMANT		ADDRESS	
BALTO MD 21229		ST AGNES RECORDS CATON & WILKENS AVES	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		Cardiorespiratory Failure	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Due to Prematurity & Hyaline	
		(C) Membrane disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0		NO	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from JUNE 29 19 70 to JULY 4 19 70 that (X) (we) last saw the deceased alive on JULY 4 19 70 and that (X) (we) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
BAIG		7-5-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
DR BAIG, M.D.		BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		7/6/70	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Meadowridge Memorial Park - Howard County, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
JUL 8 1970 Robert E. Fisher, M.D.			
25C. FUNERAL DIRECTOR		25D. ADDRESS	
Shedding Funeral Estate		736 Edmondson Ave. Catonsville, Md. 21228	

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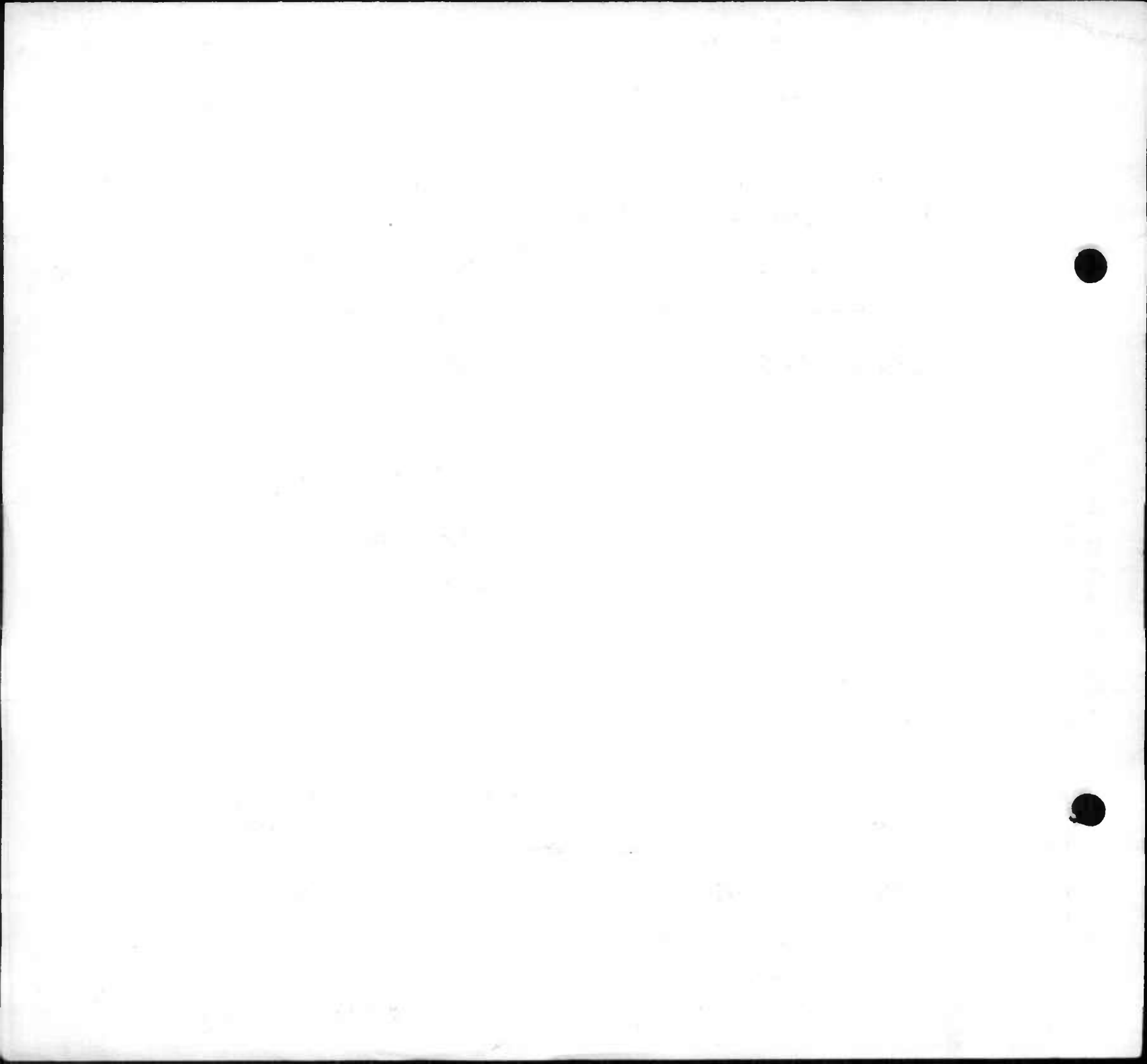
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FUNERAL DIRECTOR: IMPORTANT

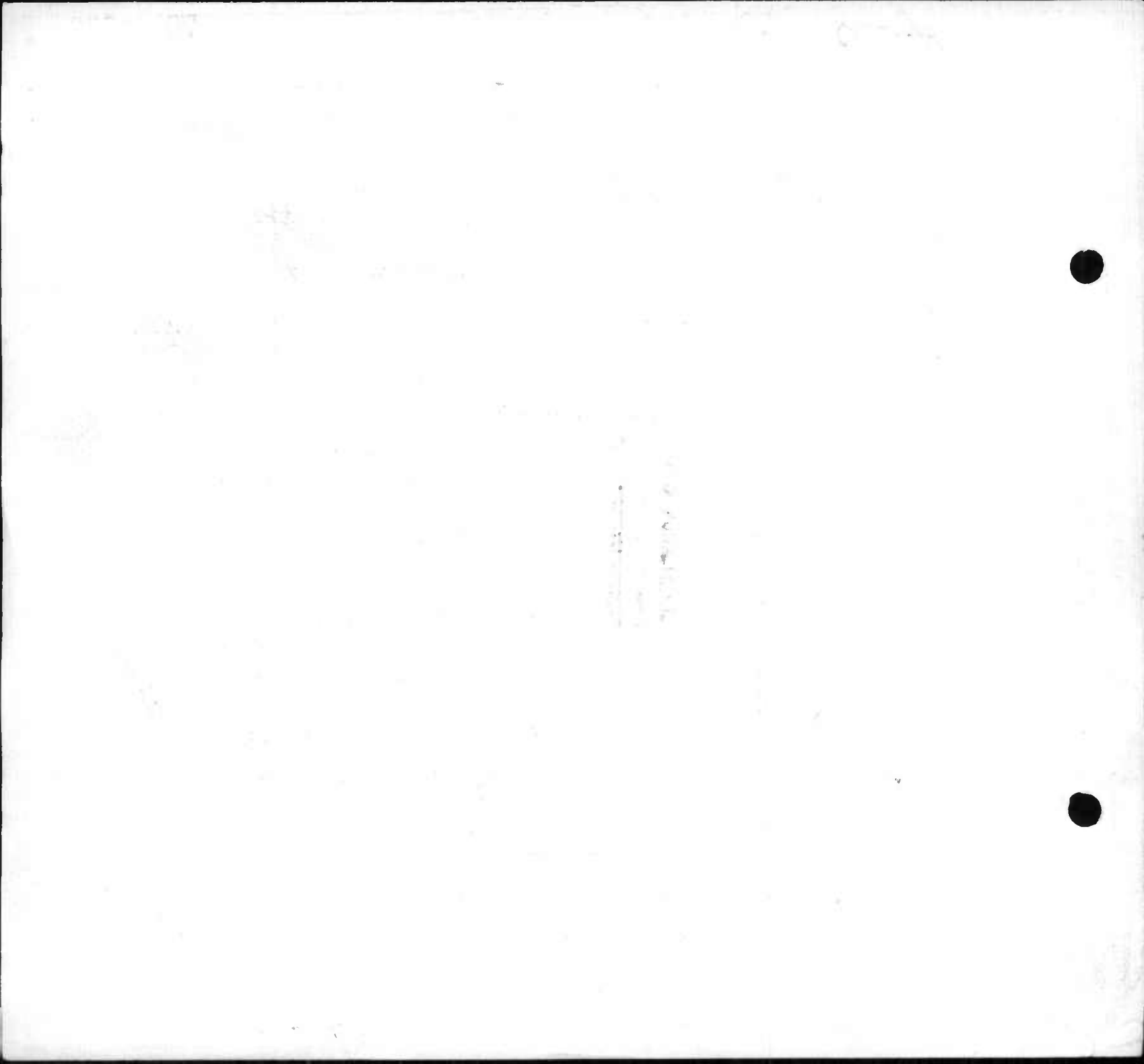
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>B-120 70 6852</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 70 6852 4</p>	
<p>BIRTH NO. 70-11812</p>		<p>2. DATE AND HOUR OF DEATH July 4, 1970 7:35 P. M.</p>	
<p>1. NAME OF DECEASED (Type or Print) RUFUS, BABY BOY</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD PREMATURE NURSERY OF JOHNS HOPKINS HOSPITAL</p>		<p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL</p>		<p>E. STREET AND NUMBER 1538 N. WOLFE STREET</p>	
<p>5. SEX M</p>	<p>6. RACE NEGRO</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH July 4, 1970</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>9. AGE (In years last birthday) 0</p>
<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME DAVID LEE WILSON</p>		<p>14. MOTHER'S MAIDEN NAME MARSHA RUFUS</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no</p>		<p>16. SOCIAL SECURITY NO. —</p>	<p>17. INFORMANT ADDRESS</p>
<p>18. 776.9 I CAUSE OF DEATH</p>			
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE PREMATURITY DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) ANOXIA DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>(C) RESPIRATORY FAILURE</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 hrs, 40 min.</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 7/4/70</p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —</p>	<p>20A. AUTOPSY? (Yes or No) YES</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Approx.)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from July 4, 1970 to July 4, 1970 that (I) was last saw the deceased alive on July 4, 1970 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Alan I. Fields M.D.</p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) ALAN I. FIELDS M.D.</p>		<p>23D. ADDRESS JOHNS HOPKINS HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Cremation</p>	<p>24B. DATE 7/4/70</p>	<p>24C. NAME OF CEMETERY or CREMATORY Johns Hopkins Hospital</p>	<p>24D. LOCATION (City, town, or county) (State) 601 N Broadway Balto., Md.</p>
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970</p>		<p>25B. NAME OF REGISTRAR Robert E. Barber, M.D.</p>	<p>25C. FUNERAL HOME ADDRESS HOSPITAL DISPOSAL</p>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-520		70 6853		BALTIMORE CITY HEALTH DEPARTMENT		70 6853	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JASPER HAMMOCK				2. DATE AND HOUR OF DEATH 07-06-70 8:11 A.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 909			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1409 ENSOR STREET			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-1-99	9. AGE (In years last birthday) 71	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Hammock				14. MOTHER'S MAIDEN NAME Kate ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 2-03-2987		17. INFORMANT Mrs. Rosie Hammock 1409 Ensor St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCVD Cardiovascular arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). BLUNT FORCE INJURY TO CHEST FALL 3 days prior to death							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1409 N. ENSOR ST., Balto			
21D. TIME OF INJURY (APPROX.) 7 3 70		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? ALLEGEDLY FELL DOWN STAIRS AT HOME			
22. I certify that (I) (this hospital) attended the deceased from 7/4 19 20 to 7/7 19 20 that (I) (we) last saw the deceased alive on 7/4 19 20 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harvey G. Klein M.D.				23B. DATE SIGNED July 7, 1970			
23C. PHYSICIAN'S NAME (Type) HARVEY G. KLEIN M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) transit-burial		24B. DATE 7-11-70		24C. NAME OF CEMETERY or CREMATORY Kenbridge		24D. LOCATION (City, town, or county) (State) Kenbridge, Va.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR 1735 Harford Ave. 22118 Marshall W. Jones, Jr.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 6854		REG. NO. 70 6854	
BIRTH NO.		70 6854		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print)		Mary Willis		2. DATE AND HOUR OF DEATH 7-6-70 9:16 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1303		5. CITY OR TOWN Balto.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 Sinai Hospital & Baltimore		E. STREET AND NUMBER 1556 Rickland St. Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. RACE Negroid	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 7-3-03	10. AGE (In years last birthday) 67	11. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME William Dorsey		14. MOTHER'S MAIDEN NAME Julia Sample		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-24-4970		17. INFORMANT Charles Willis	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Hemorrhage the probable cause of the 5th brain			
		(B) DUE TO, OR AS A CONSEQUENCE OF: Primary & old-oldenrod Cerebral			
		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from 7-6-70 to 7-6-70 that (I) (we) last saw the deceased alive on 7-6-70 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rodolfo S. Victoria		23B. DATE SIGNED 7-6-70		23C. PHYSICIAN'S NAME (Type) RODOLFO S. VICTORIA M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-70		24C. NAME OF CEMETERY OR CREMATORY The Calverton Co. Balto.	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR V. Ballen 1348 N. Calverton St.	



1
5-530

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 6855
BIRTH NO. 68-07931

70 6855
REG. NO.

1. NAME OF DECEASED (Type or Print) Danya Snead				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 7 6 70 4:50 p.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospitals (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour 7 6 70 4:50 p.m.			
6. SEX female				7. RACE colored			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN Baltimore			
9. DATE OF BIRTH 4-24-68				10. AGE (in years last birthday) 2			
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) no				17. SOCIAL SECURITY NO. none			
15. MOTHER'S MAIDEN NAME Deborah Jews				18. INFORMANT Deborah Snead			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 814.1				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street			
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 7 6 70 4:30 p.m.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1200 Blk. URBAN WAY				22F. HOW DID INJURY OCCUR? pedestrian run over by auto			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				DATE SIGNED 7/7/70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7-10-70			
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			
25C. FUNERAL DIRECTOR Kelson F.O.				ADDRESS 1348 Calhoun St.			

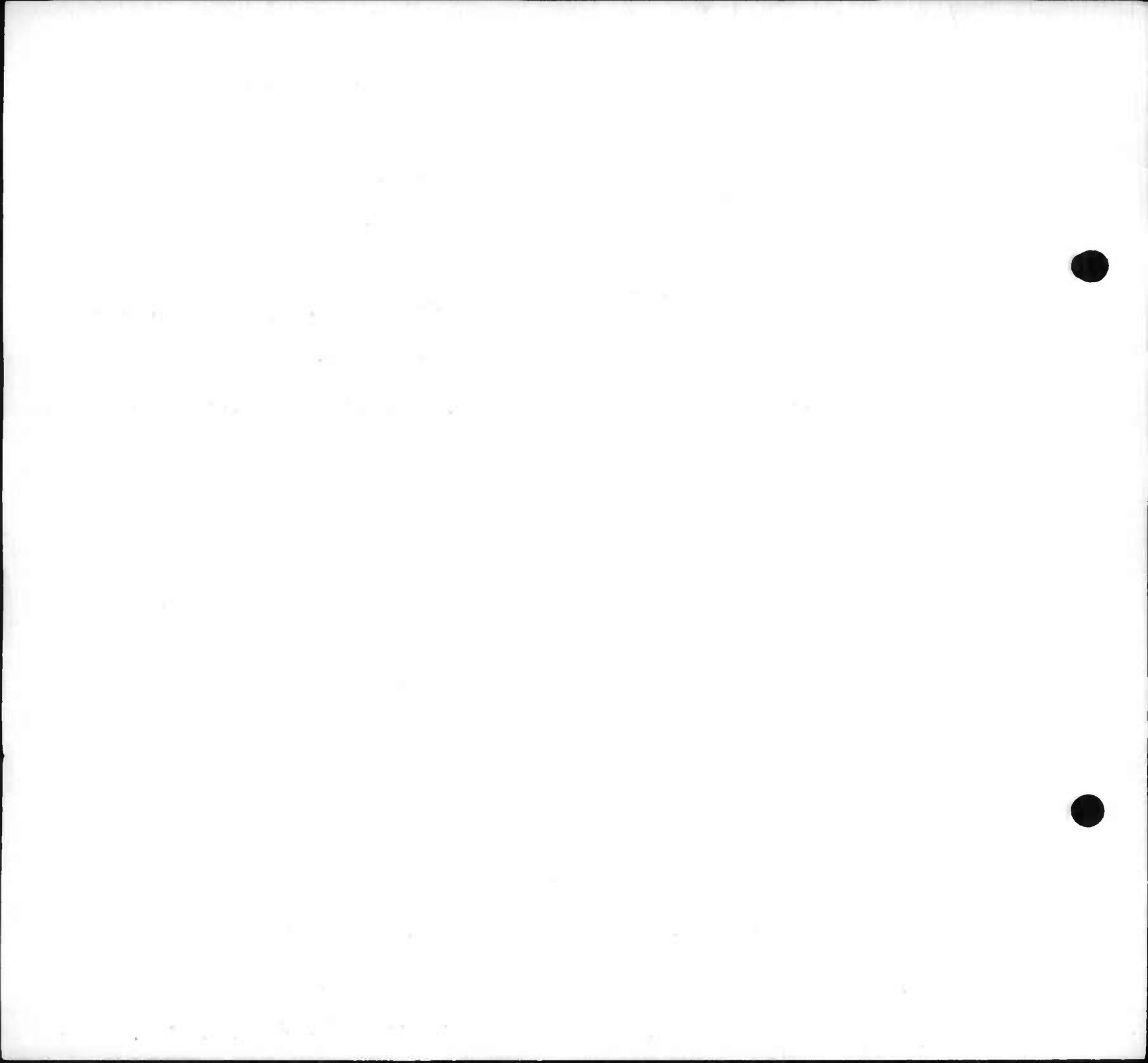
ACADEMY BOND

TRANS CENTER

QUALITY PAPER CO.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

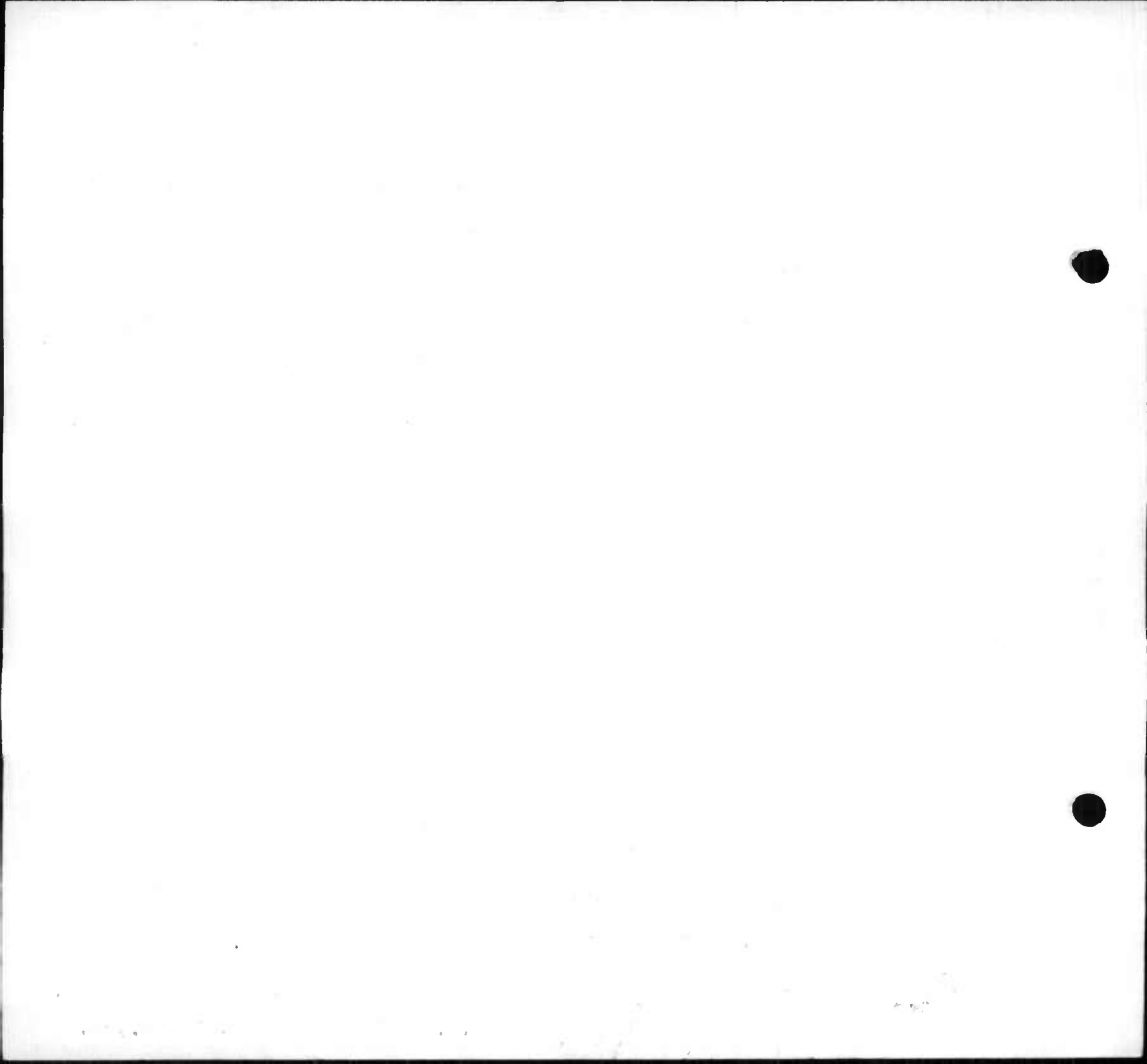
BIRTH NO.		70 6856		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		70 6856	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
Frank M. Hines				July 6, 1970					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY					
00 609 Reservoir Street				Maryland 1101					
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
M				W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9-28-1913	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Registrar				Conservatory Peabody		Louisville, Ky.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Dennis Hines				Gertrude M. Purcell					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes WWII				401-09-7422		Mr. Robert Twynham 609 Reservoir Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE				2 1/2 months	
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
I Month () Day () Year () Hour ()				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from May 1, 1970 to July 6, 1970									
that (I) (we) last saw the deceased alive on July 2, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Dr. Philip D. Flynn				7-7-70					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Dr. Philip D. Flynn				11 E. Chase Street					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION		1 City, town, or county 1 State	
Rem. Burial				Calvary		Louisville, Kentucky			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JUL 8 1970				Robert E. Taylor, Jr.		H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

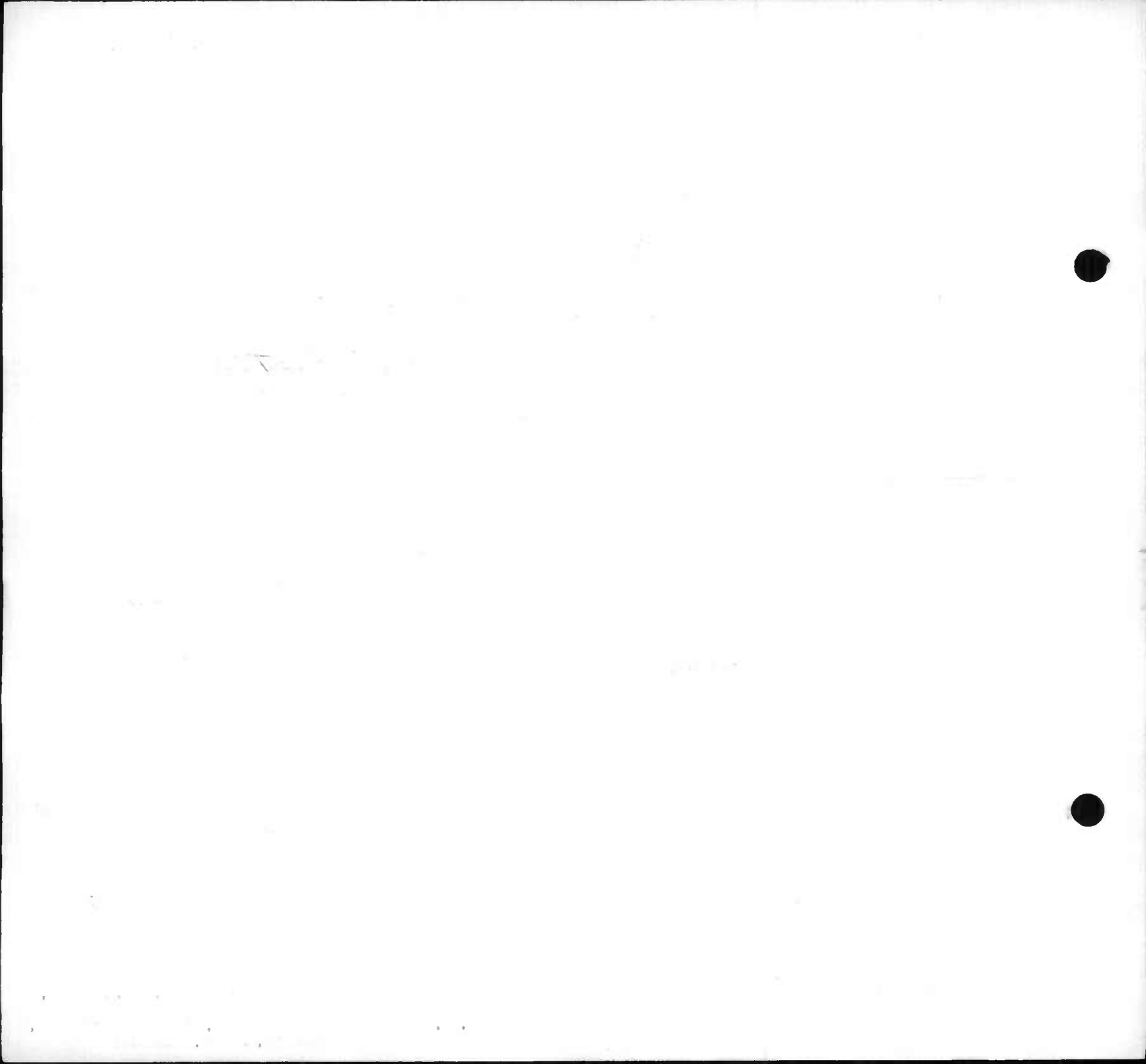
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-420 70 6857		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 6857	
1. NAME OF DECEASED (Type or Print) WALLACE, WALTER G.		2. DATE AND HOUR OF DEATH 24am 7/8/70			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hosp.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Towson D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1607 Naturo Road 21204			
5. SEX M	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-03	9. AGE (In years last birthday) 67	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Security Guard Gov't.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tennessee	
13. FATHER'S NAME Thesda Wallace		14. MOTHER'S MAIDEN NAME Maggie Wallace		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. A15-30-0020		17. INFORMANT Florence S. Wallace	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Renal-Vascular Hypertension				7 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/7 19 70 to 7/7 19 70 that (I) (we) last saw the deceased alive on 7/7 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE David J. Powner MD		23B. DATE SIGNED July 8, 1970		23C. PHYSICIAN'S NAME (Type) David J. Powner MD	
23D. ADDRESS Union Memorial Hospt.		23E. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-70		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE RECEIVED BY HEALTH DEPT. JUL 8 1970			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

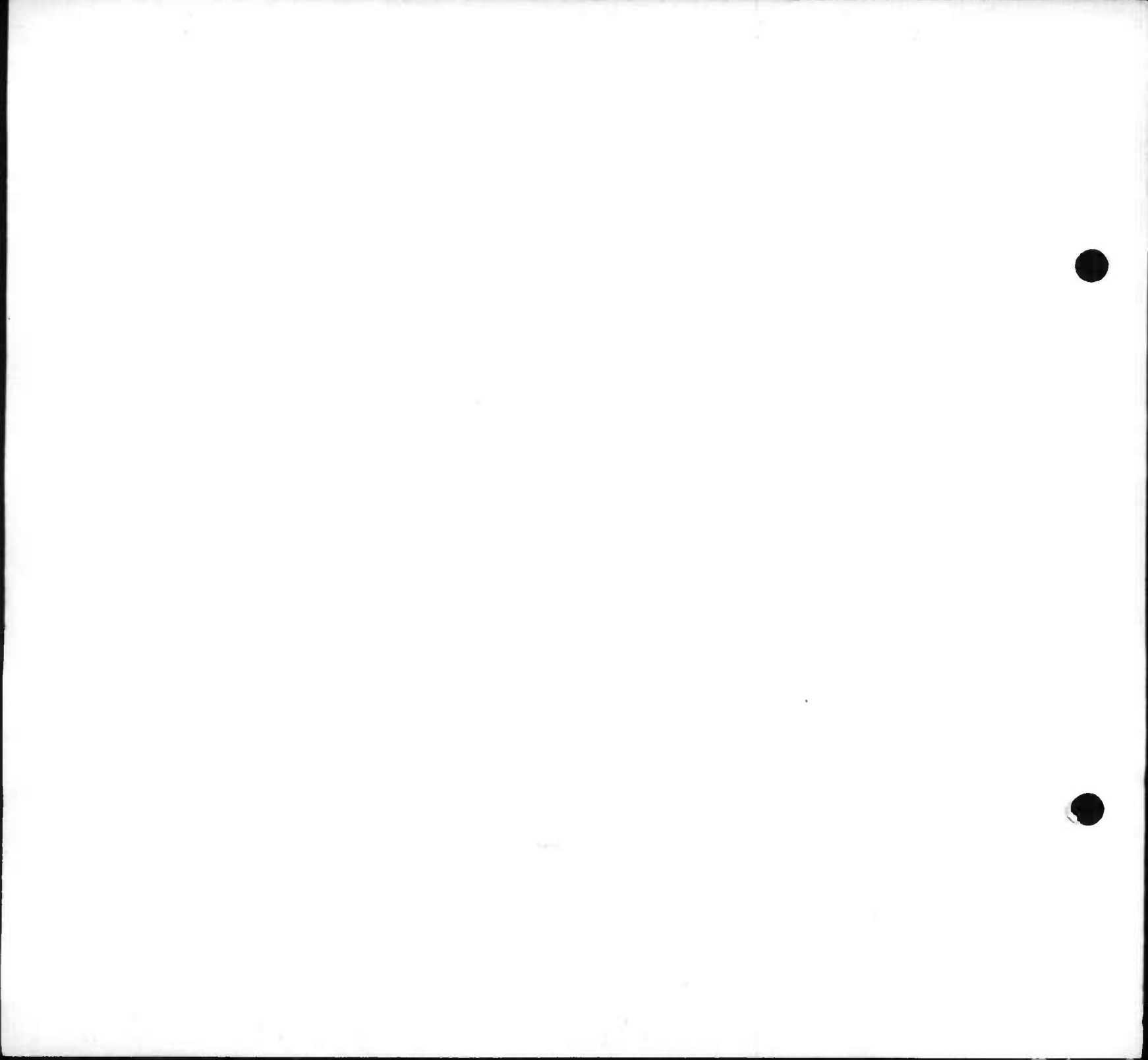
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6858	
P-626 70 6858				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BENJAMIN C. PARKHURST		2. DATE AND HOUR OF DEATH 7-8-70 19:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME & HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1201		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-18-86		9. AGE (In years last birthday) 83		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MANAGER		10B. KIND OF BUSINESS OR INDUSTRY SONOTONE CORP.		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME BENJAMIN PARKHURST		14. MOTHER'S MAIDEN NAME LILLIE ELTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 203-09-6698		17. INFORMANT CHARLES G. SUMMERS (SON) ADDRESS 35205 BIRMINGHAM ALA.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE CHF DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) BRONCHO PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos years days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from 6-26-70 to 7-8-70 that (1) (we) last saw the deceased alive on 7-8-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Alfonso A. Madarang Jr. M.D.		23B. DATE SIGNED 7/8/70		23C. PHYSICIAN'S NAME (Type) ALFONSO A. MADARANG M.D.	
23D. ADDRESS CHURCH HOME & HOSP.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/10/70	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville, Balto Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

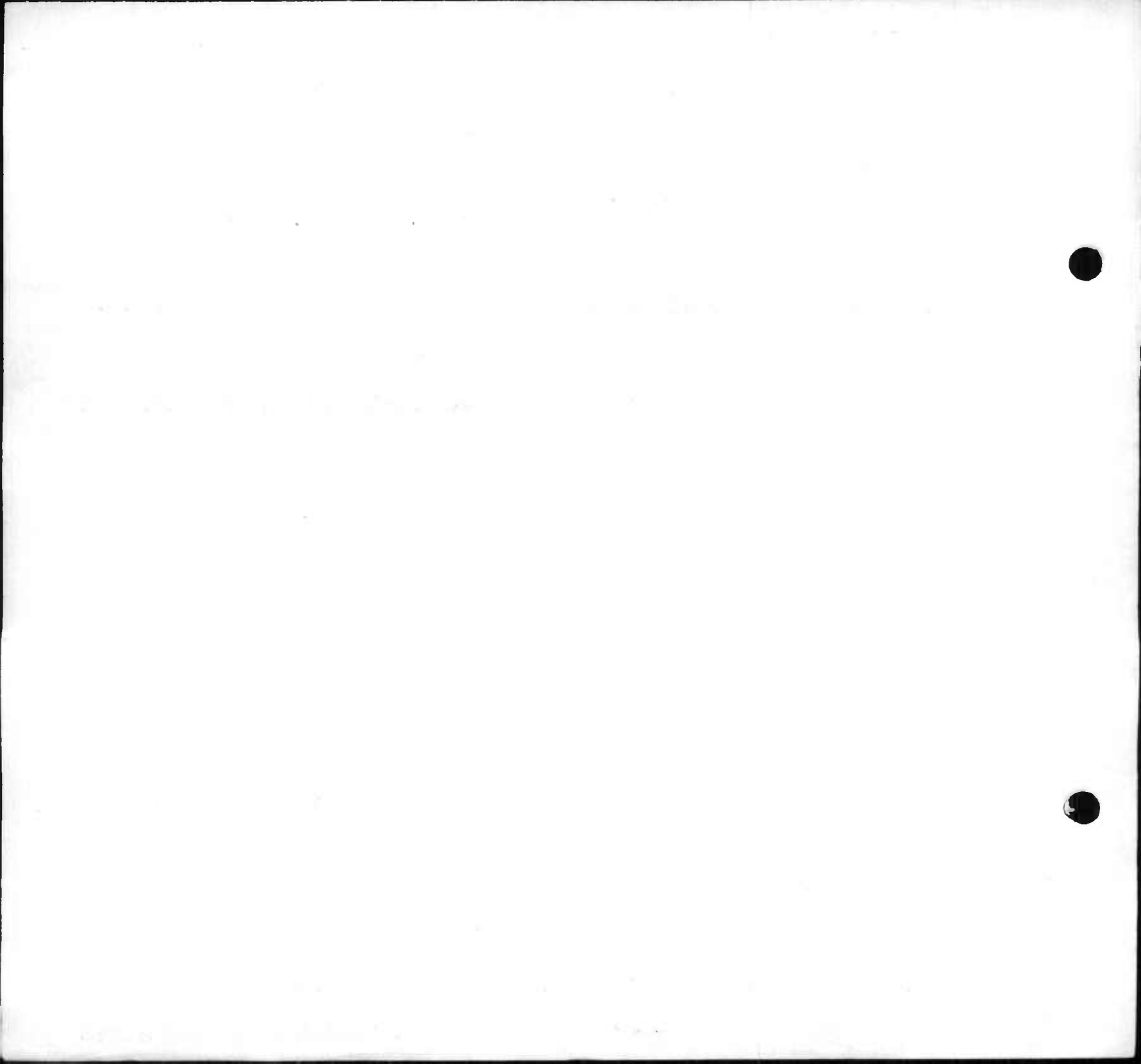
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6859</u>
BIRTH NO. <u>P-360</u>		70 6859		
1. NAME OF DECEASED (Type or Print) <u>Mary Della - Pietra</u>		2. DATE AND HOUR OF DEATH <u>7/5/70</u> <u>5¹⁵ A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> <u>2608</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3504 E. Pratt St.</u> <u>21224</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/90</u>	9. AGE (In years last birthday) <u>79</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Signorelli</u>		
14. MOTHER'S MAIDEN NAME <u>Cartasegna</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>		
16. SOCIAL SECURITY NO. <u>212-18-9979</u>		17. INFORMANT <u>Mr. Della Pietra - son</u>		
18. <u>750X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA of ESOPHAGUS - metastatic 6 weeks ago</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?		22. I certify that (we) (this hospital) attended the deceased from <u>July 4</u> 19 <u>70</u> to <u>July 5</u> 19 <u>70</u> that (we) last saw the deceased alive on <u>July 5</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Manuel Galdo</u>		23B. DATE SIGNED <u>7/5/70</u>		23C. PHYSICIAN'S NAME (Type) <u>MANUEL GALDOS</u>
23D. ADDRESS <u>BON SECOURS HOSPITAL</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>7/8/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Oaklawn Cem</u>		24D. LOCATION (City, town, or county) (State) <u>Balto-Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 8 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Tenney, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph M. Zannino Jr 263 Shockley St</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

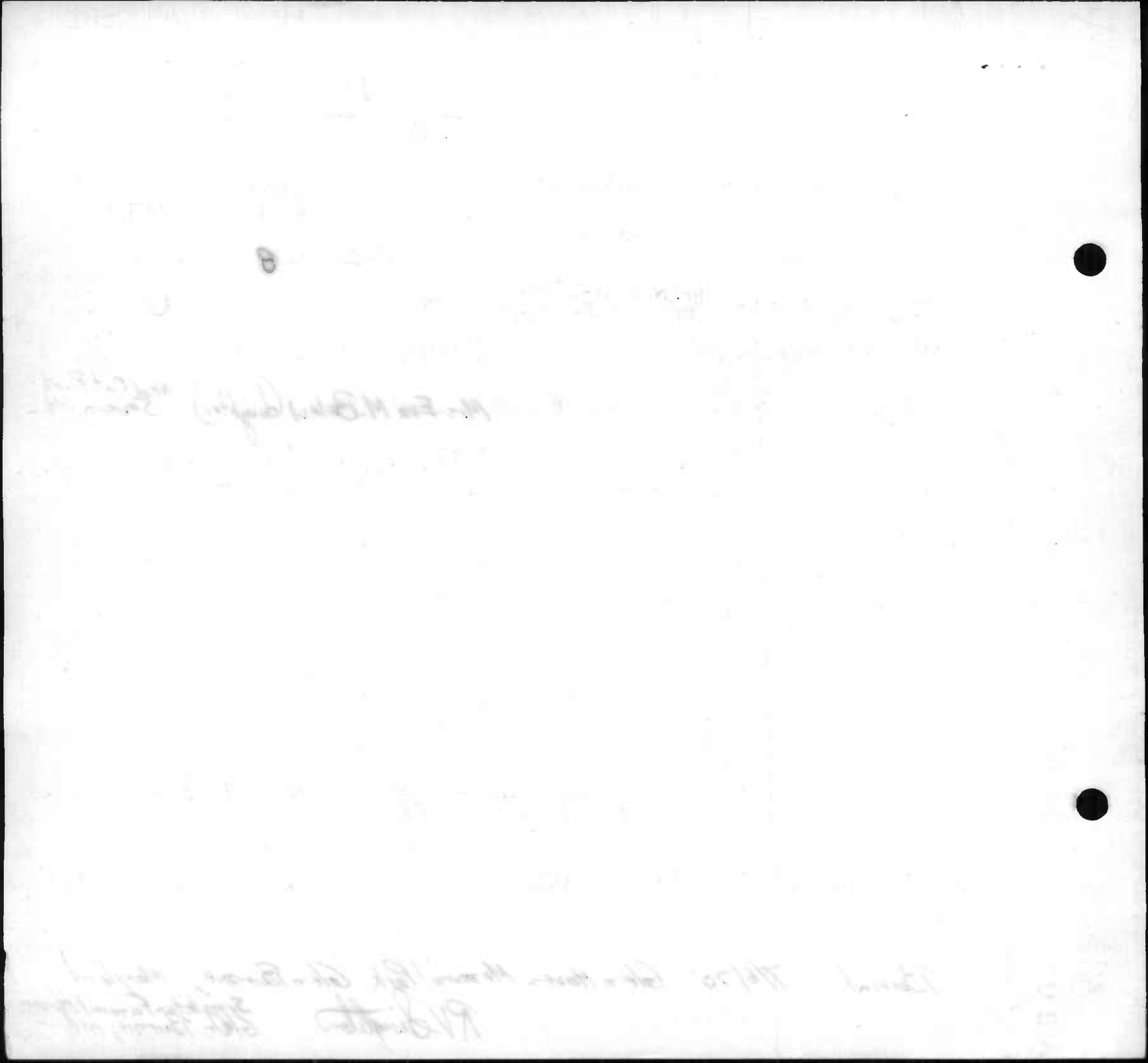
<p>BIRTH NO. 0-200 70 6860</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 70 6860</p>			
<p>1. NAME OF DECEASED (Type or Print) Ossie, Benjamin</p>		<p>2. DATE AND HOUR OF DEATH 7/1/70 12:50 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2608 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 221 S. Grundy St. #21224</p>	
<p>5. SEX Male</p>	<p>6. RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 5/17/02</p>
<p>9. AGE (In years last birthday) 68</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter</p>	<p>11. BIRTHPLACE (State or foreign country) Italy</p>
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>		<p>13. FATHER'S NAME John Ossie</p>	
<p>14. MOTHER'S MAIDEN NAME unk.</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no.</p>	
<p>16. SOCIAL SECURITY NO. 213-07-8573</p>		<p>17. INFORMANT ADDRESS Mrs. Mary Ossie, 221 S. Grundy Street #21224</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE Sclerotic cardio-vascular disease. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) CHRONIC DISTANT DISEASE Chronic obstructive lung disease.</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (N) (this hospital) attended the deceased from July 1st 1970 to July 1st 1970 that (N) (we) last saw the deceased alive on July 1st 1970 and that (N) (our) opinion death occurred on the date and hour and from the causes stated above. (N) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Patrick A. Molony M.D.</p>		<p>23B. DATE SIGNED 7/1/70</p>	
<p>23C. PHYSICIAN'S NAME (Type) PATRICK A. MOLONY</p>		<p>23D. ADDRESS MERCY HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 7/6/70</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor</p>	
<p>25C. FUNERAL DIRECTOR Joseph M. Zannino</p>		<p>ADDRESS 263 S. Conkling Street</p>	



FUNERAL DIRECTOR: IMPORTANT

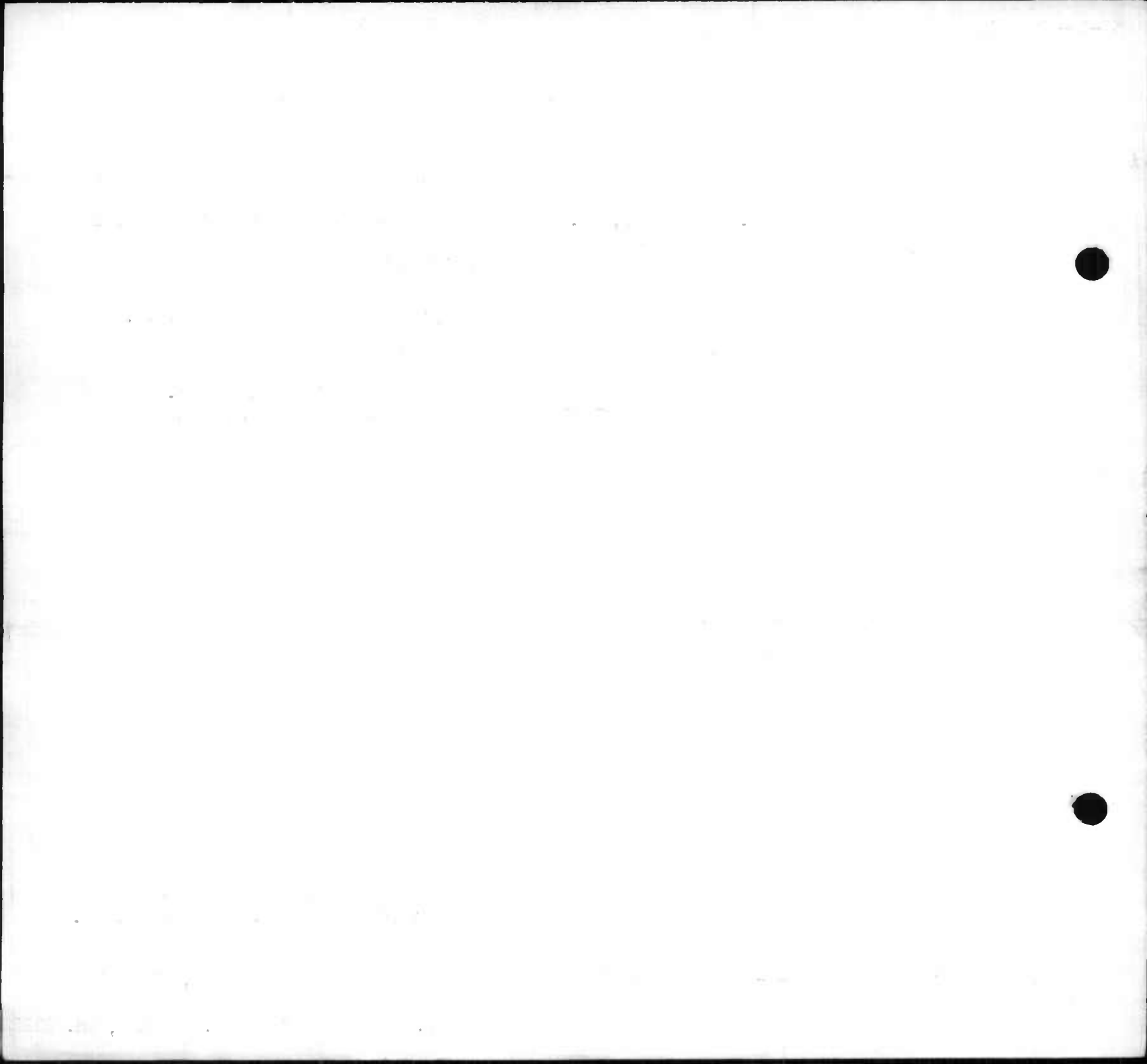
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	REG. NO.	70 6861
L-320 70 6861		LWEATKE				
1. NAME OF DECEASED (Type or Print)		Eva M. Lweatke		2. DATE AND HOUR OF DEATH 7-3-70 3:25 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				1410 HOUGHTON RD, GLEN BURNIE, MD -		
SOUTH BALTIMORE GENERAL HOSP.				C. CITY OR TOWN GLENBURNIE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
				E. STREET AND NUMBER (COUNTY) ANNE ARUNDEL COUNTY 5200		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-21	9. AGE (In years lost birthday) 48	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stitcher at Box Factory		10B. KIND OF BUSINESS OR INDUSTRY HORNOR WALDORF BOX CORP - ODENTON, MD.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME WILLIAM HYNSON				14. MOTHER'S MAIDEN NAME EMMA WILDER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-16-0333		17. INFORMANT Mrs. Eva M. Belen (Daughter)		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4 - 8 - 1970 to 7-3-1970, that (I) (we) last saw the deceased alive on 7-3-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Clement C. Ugorji M.D.				23B. DATE SIGNED 7-3-70		23C. PHYSICIAN'S NAME (Type) Clement C. Ugorji M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/6/70		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park
24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland				25A. TIME REC'D BY HEALTH DEPT. JUL 8 1970		
25B. NAME OF REGISTRAR R. Singleton				25C. FUNERAL DIRECTOR R. Singleton		
25D. ADDRESS Singleton Funeral Home				25E. ADDRESS Glen Burnie, Md.		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.	
L-340		70 6862		X		70 6862	
1. NAME OF DECEASED (Type or Print) IMA MYRTLE LIDDLE IMA M. LIDDLE				2. DATE AND HOUR OF DEATH 7/6/70 5:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital 4940 Eastern Ave. Baltimore, Md. 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8317 Bear Creek Drive 21222 005			
5. SEX Female	6. RACE W Hite	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/21	9. AGE (In years last birthday) 49	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charlie Bedsaul				
14. MOTHER'S MAIDEN NAME Nina Parrish			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 219-42-1327			17. INFORMANT BCH Records: Baltimore, Md 21224				
18. 4-31-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anoxia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Subarachnoid hemorrhage			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min. 6 days				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/1 19 70 to 7/6 19 70 that (I) (we) last saw the deceased alive on 7/6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jerome L. Fleg M.D.				23B. DATE SIGNED 7-6-70			
23C. PHYSICIAN'S NAME (Type) Jerome L. Fleg M.D.				23D. ADDRESS 4940 Eastern Ave. Baltimore, Md. Baltimore City Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-70		24C. NAME OF CEMETERY or CREMATORY Gladeville Cemetery		24D. LOCATION (City, town, or county) (State) Carroll County, Virginia	
25A. DATE REC'D BY HEALTH DEPT. JUL 8 1970		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md. 21222			



R-360

1

BALTIMORE CITY HEALTH DEPARTMENT

70 6863 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6863

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Merritt Lewis</u> <u>XXXXXXXXX Reeder</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 South Balto. General Hospital</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>7 7 70 4:40 a.</u> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1701</u>			
6. SEX <u>male</u>	7. RACE <u>white</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <u>Baltimore</u>
9. DATE OF BIRTH <u>5 - 13 - 1893</u>		10. AGE (In years last birthday) <u>77</u>	E. STREET AND NUMBER <u>409 Orchard Rd. Ave.</u>
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Jasper Reeder</u>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Maintenance</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>Continental Oil Co.</u>	15. MOTHER'S MAIDEN NAME <u>Ellen Hoar</u>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. II</u>		17. SOCIAL SECURITY NO. <u>213-05-6556</u>	18. INFORMANT ADDRESS <u>Mrs. Pauline Reeder 409 Orchard Ave.</u>
19. CAUSE OF DEATH <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic cardiovascular disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1701</u>
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? _____		22G. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? _____	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> Deputy Chief Medical Examiner DATE SIGNED <u>7/7/70</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-10-70</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>McCully Funeral Home</u>		ADDRESS <u>21225 Potapsc Ave.</u>	

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Carmine, Gertrude Mary		2. DATE AND HOUR OF DEATH 7/6/70 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 8-10-70 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2636 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1117 Anglesea Street 21224	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/1883	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Lady		10B. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal Sparks Sparks		11. BIRTHPLACE (State or foreign country) Maryland, Chestertown	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sparks		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest 5-10 min		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Embolus 2-3 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Fractured Left Hip 2 weeks		19A. DATE OF OPERATION 16		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fx. Lt. Hip	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? 1117 Anglesea St Balt. Md 2636		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 6 17 70 4pm	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? pt was carrying a flattened something not a fall.		22. I certify that (I) (this hospital) attended the deceased from 6/17 19 70 to 7/6/ 19 70 , that (I) (we) last saw the deceased alive on 7/6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Allan Krumholtz		23B. DATE SIGNED 7/6/70		23C. PHYSICIAN'S NAME (Type) Allan Krumholtz	
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/70	
24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970	
25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane		25D. ADDRESS	

RELEASED ON APPROVAL OF MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Letter from B.C.H. 8-10-70 R.H.

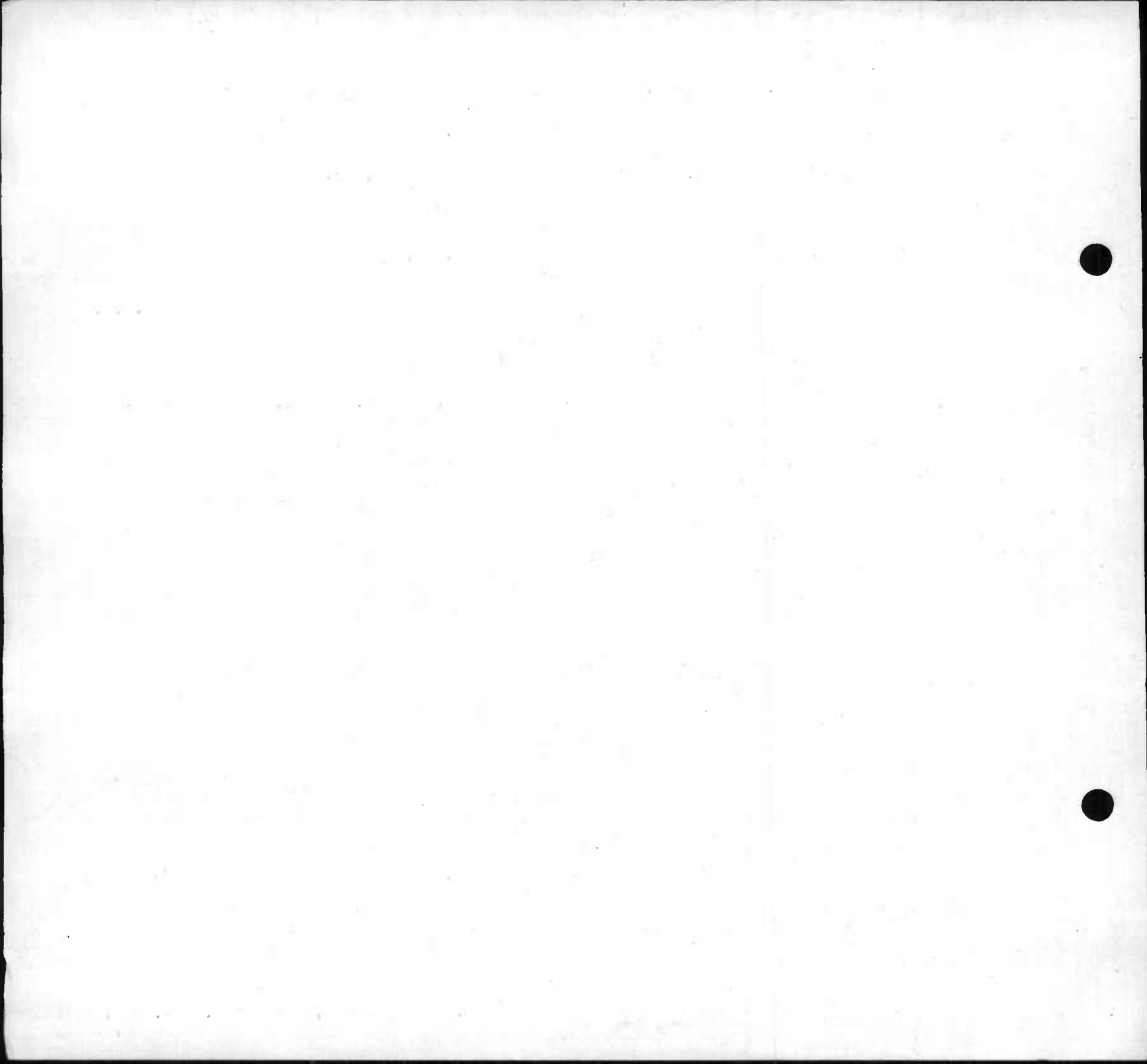
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6865	
S-400 70 6865		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) ANDREW SCHLee		July 6-1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hosp.		A. STATE MD B. COUNTY BALTO. 53.00	
		C. CITY OR TOWN Essex	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 322 STILLWATER RD.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-11
		9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Sears-Roebuck	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME ANDREW SchLee		14. MOTHER'S MAIDEN NAME MARY Biggs	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT WIFE ADDRESS SAME
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction		1/2 Hour	
(B) Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF:		5 years	
(C) Hypertension		5 year	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from May 1965 19 to July 5 1970, that (I) (we) last saw the deceased alive on July 5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE Morris A. Jacobs M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 7/7/70
23C. PHYSICIAN'S NAME (Type) MORRIS A. JACOBS M.D.		23D. ADDRESS 1010 N. Point Road	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 7/9/70	24C. NAME of CEMETERY or CREMATORY CAK-LAWN	24D. LOCATION (City, town, or county) (State) BALTO MD.
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970	25B. NAME OF REGISTRAR Robert E. Kelly	25C. FUNERAL DIRECTOR ADDRESS J. G. Connelly Sons Essex MD	

FUNERAL DIRECTOR: IMPORTANT

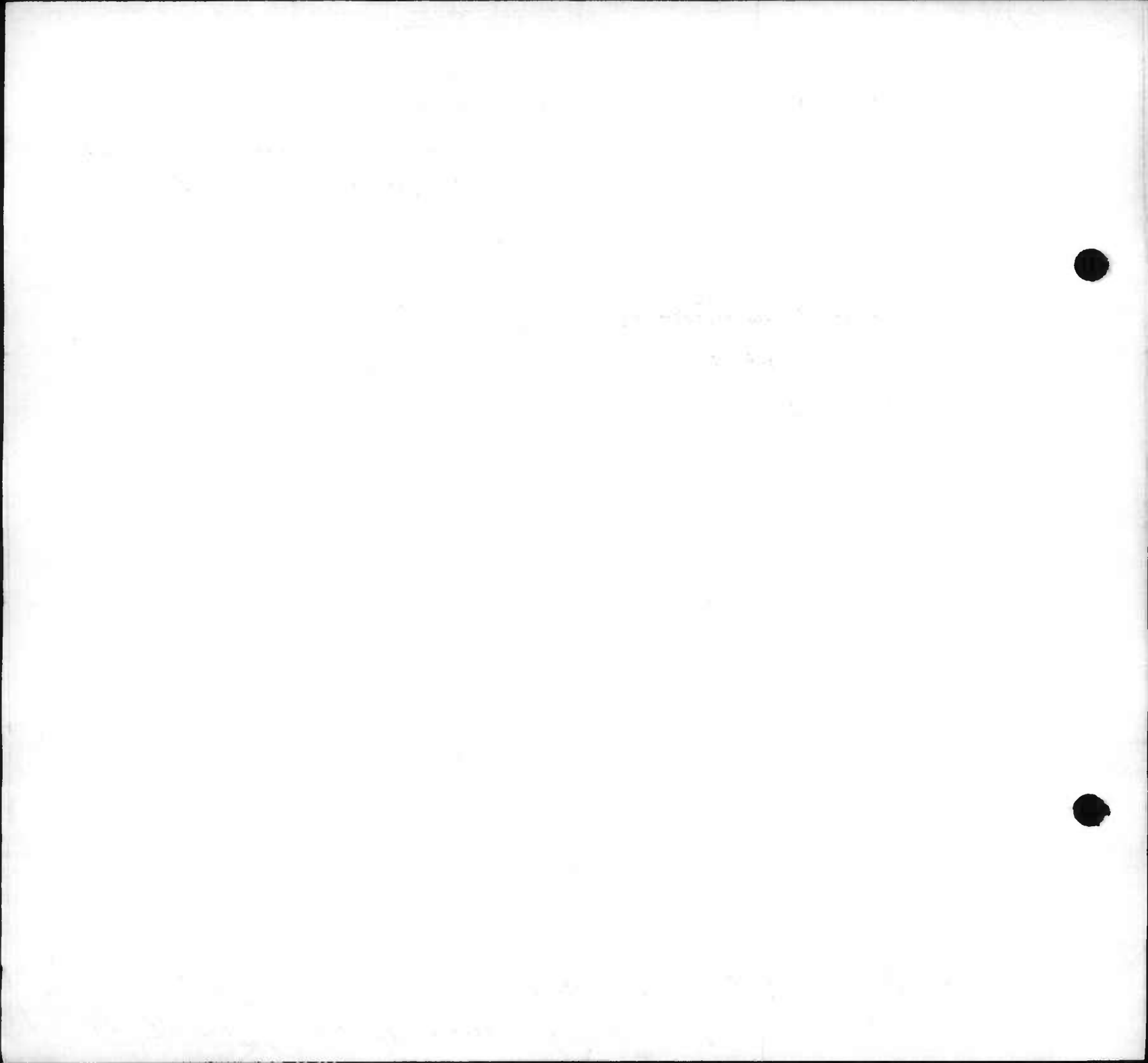
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6866	
<div style="display: flex; justify-content: space-between;"> M-625 70 6866 </div>					
<div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Garner E. Morgan, Sr.			2. DATE AND HOUR OF DEATH July 5, 1970 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 513 Random Rd.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2531		
5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Feb. 16, 1898 9. AGE (In years last birthday) 72		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10B. KIND OF BUSINESS OR INDUSTRY Self employed		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Morgan			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-14-1075		
17. INFORMANT Mr. Mary M. Morgan, 513 Random Rd., Baltimore			ADDRESS		
18. 1990 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			ASCVD		
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 3/25/70 19 70 to July 5 19 70 , that (I) (we) last saw the deceased alive on 6/27 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.					
23A. SIGNATURE Earl Pass MD			23B. DATE SIGNED 7/7/70		
23C. PHYSICIAN'S NAME (Type) I. EARL PASS			23D. ADDRESS 4001 Wickersville Blvd		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE July 9, 1970		
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			24D. LOCATION (City, town, or county) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970			25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		
25C. FUNERAL DIRECTOR G. Truman Schwab			ADDRESS 5151 Balto. Natl. Pike, Baltimore Maryland, 21229		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

70 6868

BIRTH NO.

70 6868

1. NAME OF DECEASED
(Type or Print)

Lenora V. Wise

2. DATE AND HOUR OF DEATH

7-8-70

8:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)S. Balt. Gen. Hosp.
3000 So. Hanover St
~~7000 Light St.~~ Balt. Md.4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1828 Belt St

5. SEX

F

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

11-2-22

9. AGE (In years
last birthday)

47

If Under 1 Yr.

Months

If Under 24 Hrs.

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Elmer Schelhouse - Dec.

14. MOTHER'S MAIDEN NAME

Anna Mae Hodges dec.

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Charles L. Wise 1828 Belt St.

18.

230-9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Diabetes Mellitus

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner) ☐
no21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 6-18-70 19 70 to 7-8-70 19 70
that (1) (we) last saw the deceased alive on 7-8-70 19 70 and that in (1) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.

23A. SIGNATURE

Daniel M. Howell

DEGREE

Attending ☐ Phys.Med. Director ☐Staff ☒ Phys.

23B. DATE SIGNED

7-8-70

23C. PHYSICIAN'S
NAME (Type)

Daniel M. Howell

DEGREE

23D. ADDRESS

132 W Lafayette Ave Balt. Md.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7 11 70

24C. NAME OF CEMETERY or CREMATORY

Glen Haven

24D. LOCATION

(City, town, or county)

(State)

Glen Burnie, A. A. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 9 1970

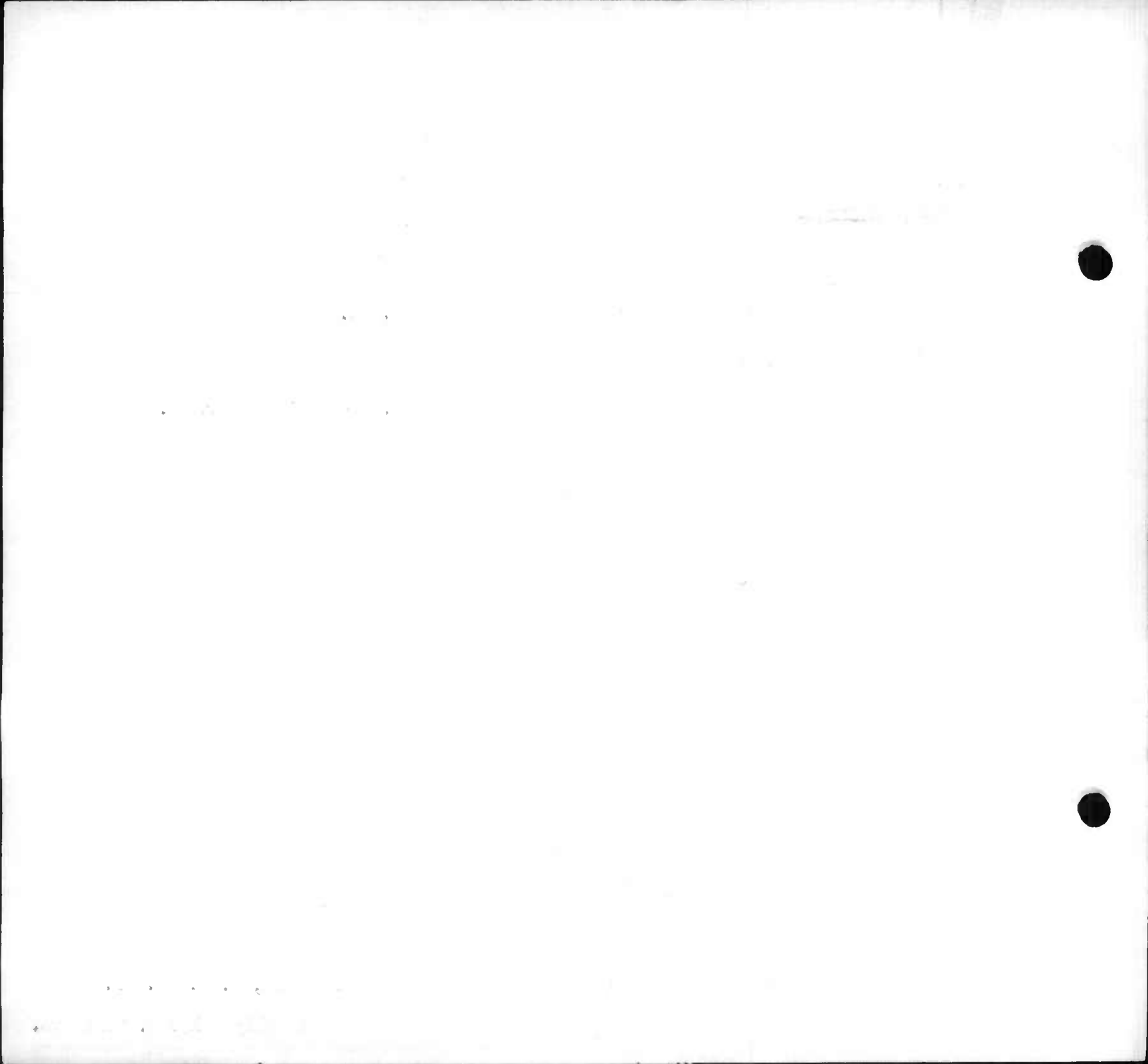
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Mc Cully 130 E. Fort Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6869		REG. NO. 70 6869			
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				WECKESSER, MATILDA		JULY 5, 1970 6:15A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE MARYLAND		B. COUNTY 21223 2005			
ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 2616 LEHMAN STREET					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-02-00	9. AGE (in years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND				
13. FATHER'S NAME HECK			14. MOTHER'S MAIDEN NAME Schmidt		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215246535		17. INFORMANT BALTIMORE, MD. 21229 ADDRESS ST AGNES HOSPITAL, WILKENS & CATON AVES.				
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating whether UNDERLYING CONDITION lost.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>				<p>19. CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE Wound Infection, (R) hip</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Ex (R) Hip</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>1 mo</p>			
19A. DATE OF OPERATION May 30		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Wound Infection (R) hip		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2616 Lehman St. 2005					
21D. TIME OF INJURY (Approx.) 5 25 20 03 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fell while getting out of bed					
22. I certify that (X) (this hospital) attended the deceased from JUNE 9 1970 to JULY 5 1970 that (X) (we) last saw the deceased alive on JULY 5, 1970 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.									
23A. SIGNATURE Eugene Wilk Jr. M.D.				23B. DATE SIGNED 5 JUL 70		23C. PHYSICIAN'S NAME (Type) DEGREE			
23D. ADDRESS DEGREE									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 8, 1970		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970		25B. NAME OF REGISTRAR Robert E. Jarboe, M.D.		25C. FUNERAL DIRECTOR G. Truman Schwab, 5151 Balto. Natl. Pike, Baltimore, Md. 21229		ADDRESS			

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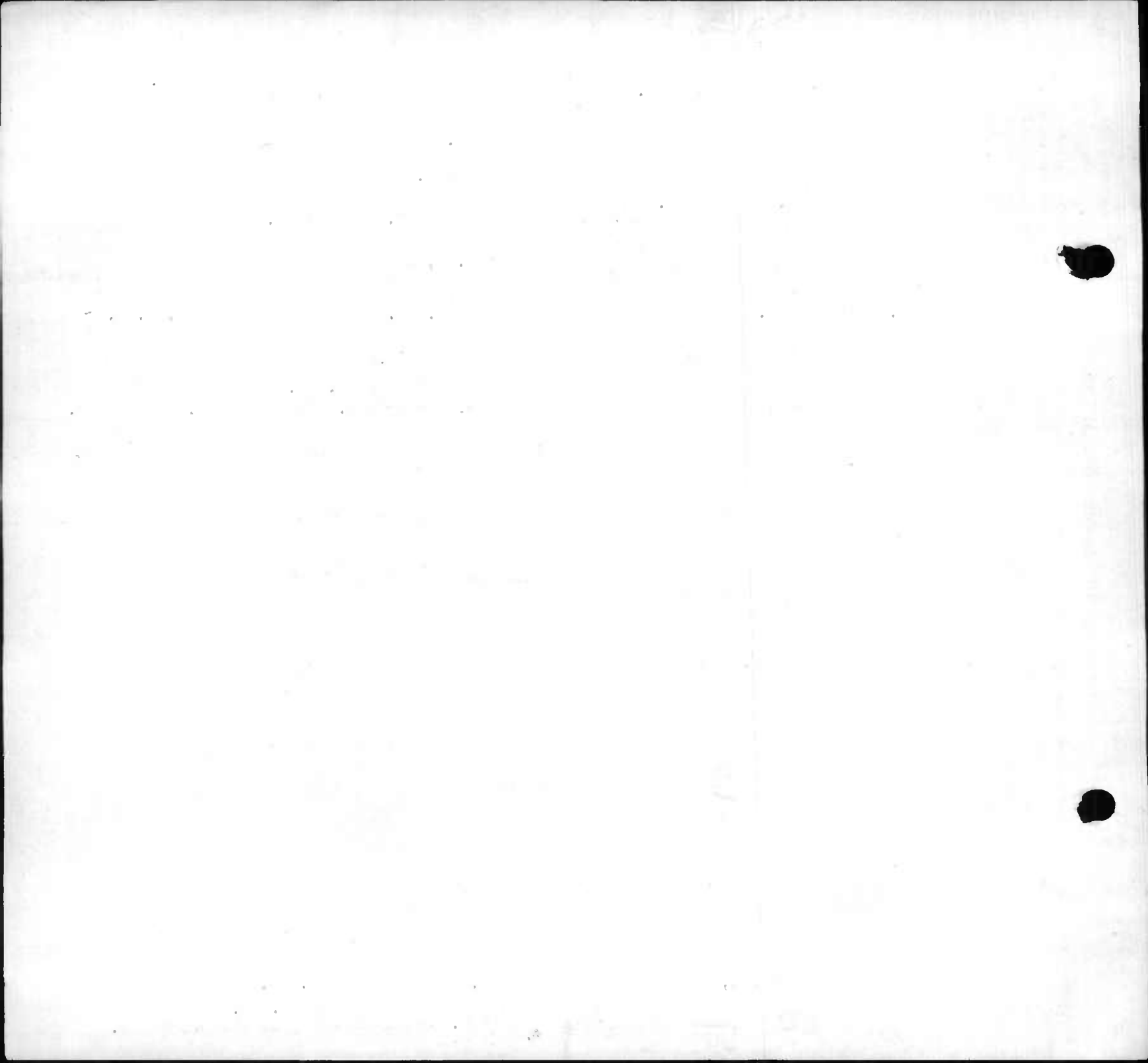
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6870		CERTIFICATE OF DEATH		REG. NO. 70 6870	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				Mathew Matthew P. Hawkins		July 3, 1970 8:00 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md.		C. CITY OR TOWN D. INSIDE CITY LIMITS?			
00 205 S. Wickham Rd.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				205 S. Wickham Rd.					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.			
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 3, 1891	78					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Ret. Railway Exp.						Balto. Md.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Patrick Hawkins				Sarah Flynn					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
yes 1918-1919						Balto. Md. 21229		Mrs. Victoria C. Hawkins 205 S. Wickham Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				Crown Occlusion				Sudden	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				Cardio Vascular Disease				10 years	
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) Ischemic Heart Disease					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
				White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/1/70 1958 to 7/3/70 19, that (I) (we) last saw the deceased alive on 7/2/70 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
E. J. Schuman								7/6/70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
				3437 Frederick Ave. Balto. Md. 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		July 6, 1970		New Cathedral Cem.		Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 9 1970				Robert E. Fisher, M.D.		Balto. Md.		G. Truman Schwab 3512 Frederick Ave.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6871

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RICHARD E. BRADLEY

2. DATE OF DEATH
Known ☒ Month Day Year Hour
Estimated ☐ June 27 1970 M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

3. DATE PRONOUNCED DEAD
Month Day Year Hour
6 27 1970 2:15 A.M.5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission)
A. STATE B. COUNTY

Md.

B. COUNTY

402

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7-9-1925

10. AGE (In years last birthday)

44

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

502 W. Fayette St.

11. BIRTHPLACE (State or foreign country)

New Jersey

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES B. BRADLEY

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Lap-tender

14B. KIND OF BUSINESS OR INDUSTRY

BAR-ROOM

15. MOTHER'S MAIDEN NAME

ANNA A. McMACKLIN

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes W.W.II

17. SOCIAL SECURITY NO.

141-16-9378

18. INFORMANT

Hospital chart

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Delirium tremens.

(A) IMMEDIATE CAUSE - Epilepsy
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).Chronic alcoholism, epilepsy
Arteriosclerotic cardiovascular disease, slight to moderate

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-27-70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6-30-70

24C. NAME OF CEMETERY or CREMATORY

St. Mary's Cemetery

24D. LOCATION (City, town, or county) (State)

Coldspiring - New Jersey

25A. DATE REC'D BY HEALTH DEPT.

JUL 9 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

W. J. TUCKER & SONS.

ADDRESS

North + Penn

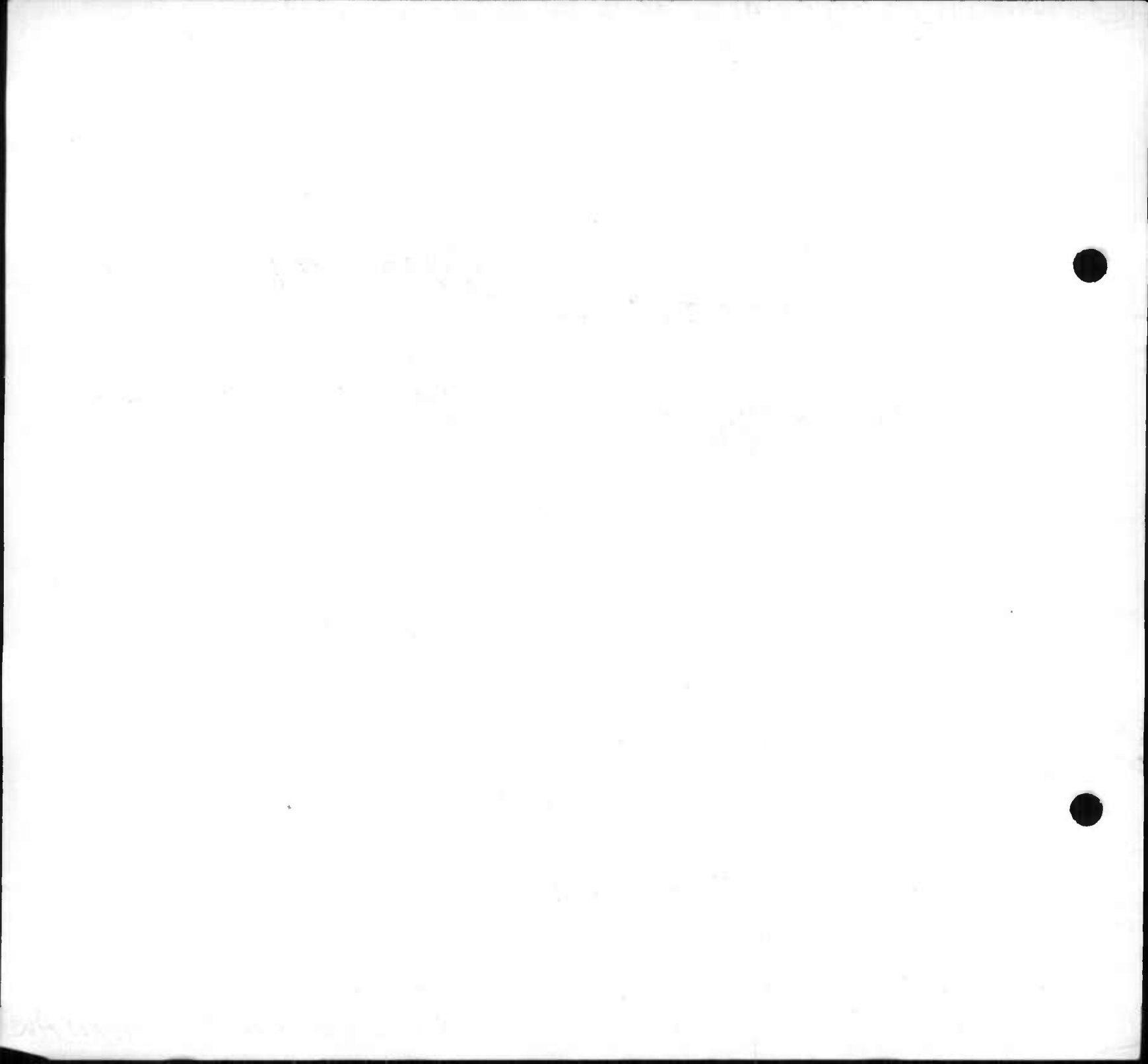
H. W. MEARS + SONS

7/9/70 - Letter from Office of the Chief
Medical Examiner dated 6/29/70. pgs.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

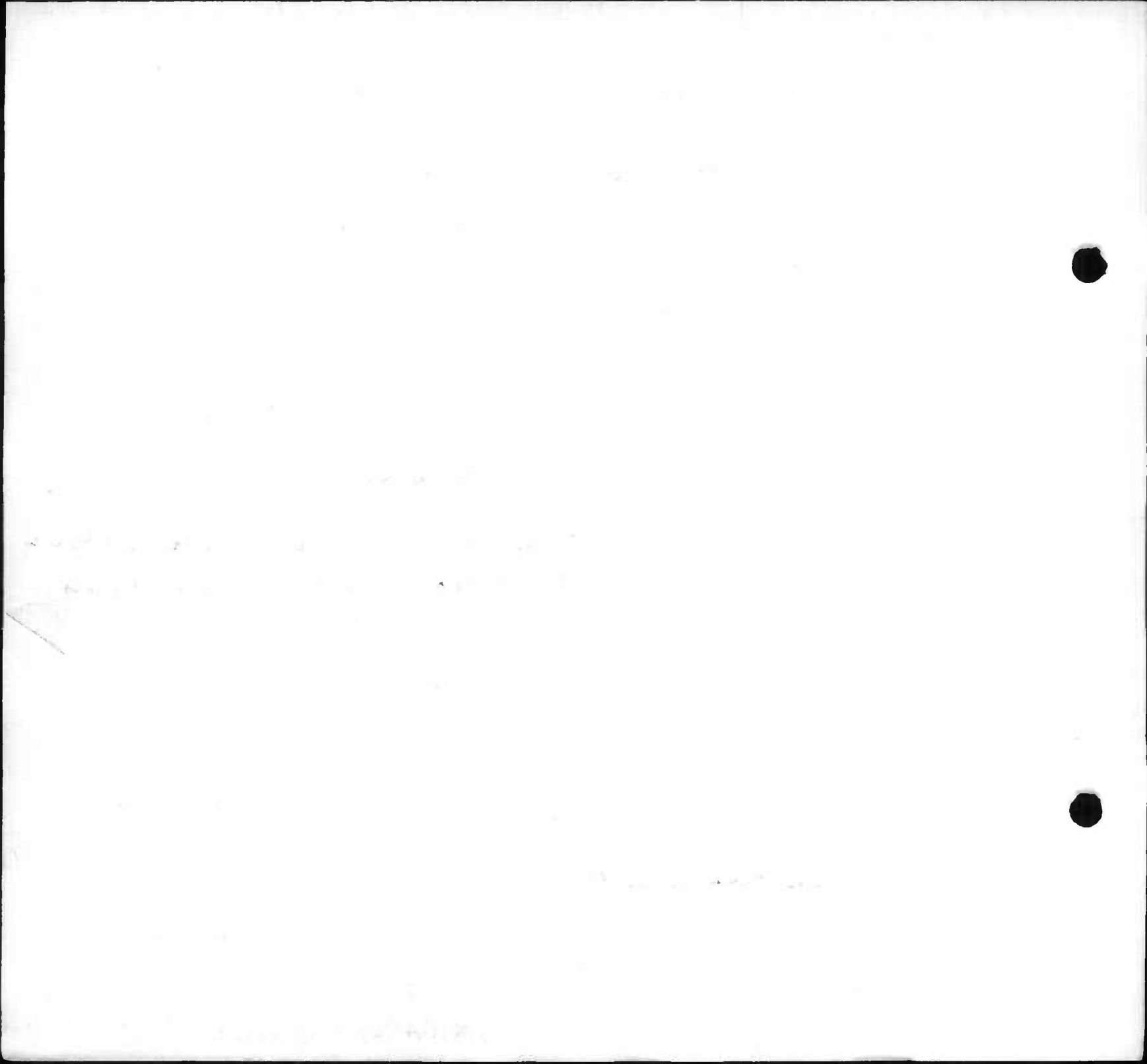
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6872	
<div style="display: flex; justify-content: space-between;"> 2-420 (ZALEWSKI) CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>EDMUND ZALEWSKI</u>		2. DATE AND HOUR OF DEATH <u>7/7/70</u> <u>8:00 pm</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME + HOSPITAL</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>203</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>100 N. BROADWAY</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1915 FLEET ST.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/93</u>	9. AGE (In years last birthday) <u>77</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIELD WORKER & FARMING</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>POLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FRANK ZALEWSKI</u>		14. MOTHER'S MAIDEN NAME <u>MARY MORAWSKI</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI-6/29/18 TO</u>		16. SOCIAL SECURITY NO. <u>213 181862</u>		17. INFORMANT <u>GENEVIEVE DANIELS</u> <u>MARION ZALEWSKI</u>	
18. <u>151.9</u> <u>12/2/18</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF CARDIA OF STOMACH</u>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>WITH UNCONTROLLED BLEEDING</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY EDEMA</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>1-2 wks</u> <u>2 days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>7/3/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bleeding from stomach</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/1/70</u> 19 to <u>7/7/70</u> 19 that (I) (we) last saw the deceased alive on <u>7/7/70</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ricardo M. Turson M.D.</u>		23B. DATE SIGNED <u>7/7/70</u>		23C. PHYSICIAN'S NAME (Type) <u>RICARDO M. TURSON M.D.</u>	
23D. ADDRESS <u>100 N. BROADWAY, BALTIMORE MD</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>7/10/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. COUNTY, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor</u>		25C. FUNERAL DIRECTOR <u>W. FIALKOWSKI - 2007 EASTERN AVE.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>B-120</u> <u>70</u> <u>6873</u>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>70</u> <u>6873</u>	
1. NAME OF DECEASED (Type or Print) <u>Gertrude Reaves</u>				2. DATE AND HOUR OF DEATH <u>7/8/70</u> <u>3:25</u> <u>A</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38</u> <u>University of Md. Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2543</u>			
5. SEX <u>F</u>				6. RACE <u>W</u> <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		8. DATE OF BIRTH <u>3/19/05</u>	
13. FATHER'S NAME <u>Joseph Kyler</u>				14. MOTHER'S MAIDEN NAME <u>Isaac</u>		9. AGE (in years last birthday) <u>65</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213 14 9858</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
17. INFORMANT <u>Denwood Reaves</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>183.01</u> <u>PRE-RENAL UREMIA</u> <u>3 weeks</u> <u>PELVIC MASS, probable OVARIANCA 6+ Months</u> <u>12 hrs</u> <u>INTESTINAL OBSTRUCTION</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>7/6/70</u> <u>1:45 PM</u> to <u>7/8/70</u> <u>3:25 AM</u> that (1) (we) last saw the deceased alive on <u>7/8/70</u> <u>1970</u> <u>AM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Sergio Perticucci M.D.</u>				23B. DATE SIGNED <u>7/8/70</u>		23C. PHYSICIAN'S NAME (Type) <u>Sergio Perticucci M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>7/12/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. AUBURN CEM.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>MARGARETA B. BROWN</u>	
25D. ADDRESS <u>3106 WILBROOK AVE</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-320 70 6874		BALTIMORE CITY HEALTH DEPARTMENT		70 6874	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Woods Frank</u>			2. DATE AND HOUR OF DEATH <u>7-8-70</u> <u>6:30 a.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secour Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2864</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4653 Manordene Rd.</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/88</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Supt</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>New Cathedral Cem</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Edward Woods</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>216-07-1930</u>		17. INFORMANT <u>Chart</u> <u>Miss Margaret Woods</u> ADDRESS <u>4653 Manordene Rd Apt B</u>
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>M YOCARDIAL</u> DUE TO, OR AS A CONSEQUENCE OF: <u>INFARCTION</u> (B) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>many yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>none</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>7-6</u> 19 <u>70</u> to <u>7-8</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7-8-70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sam B. Kerr M.B.C.</u>			23B. DATE SIGNED <u>7-8-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>IAIN C. KERR M.B. Ch.B.</u>			23D. ADDRESS <u>BON SECOUR HOSP</u> <u>2025 W. FAYETTE ST BALTO #23</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/10/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Ave., 21228</u>	
25D. ADDRESS <u>Witzke, 1630 Edmondson Ave., 21228</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-152 70 6875		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6875	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Mr (Louis) Lewis Evans</i>			
2. DATE AND HOUR OF DEATH <i>7-7-70 9 15 A.M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4 Bon Secour Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2010 W. Saratoga St. 21223</i>			
C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>21223</i>				5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>12-13-84</i>				9. AGE (In years last birthday) <i>85</i> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Rudolph Evans</i>				14. MOTHER'S MAIDEN NAME <i>Habik Catherine</i>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>215-09-9993-A</i>			
17. INFORMANT <i>Miss Pearl C. Evans</i>				ADDRESS <i>2010 W. Saratoga St. 21223</i>			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <i>Cerebro-vascular accident</i>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) <i>ASCVD.</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<i>PNEUMONIA.</i>			
19A. DATE OF OPERATION <i>None</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <i>No</i>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from <i>7-2</i> 19 <i>70</i> to <i>7-7</i> 19 <i>70</i> , that (i) was last saw the deceased alive on <i>7-5</i> 19 <i>70</i> and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death.							
23A. SIGNATURE <i>Sam B. Kerr M.D.</i>				23B. DATE SIGNED <i>7-7-70</i>			
23C. PHYSICIAN'S NAME (Type) <i>IAIN C. KERR M.D.</i>				23D. ADDRESS <i>BON SECOURS HOSP 2025 W FAYETTE ST #23</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>7/10/70</i>			
24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i>				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 9 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			
25C. FUNERAL DIRECTOR <i>Witzke, 4101 Edmondson Ave., 2229</i>				ADDRESS			

2/20/71 - 12 March

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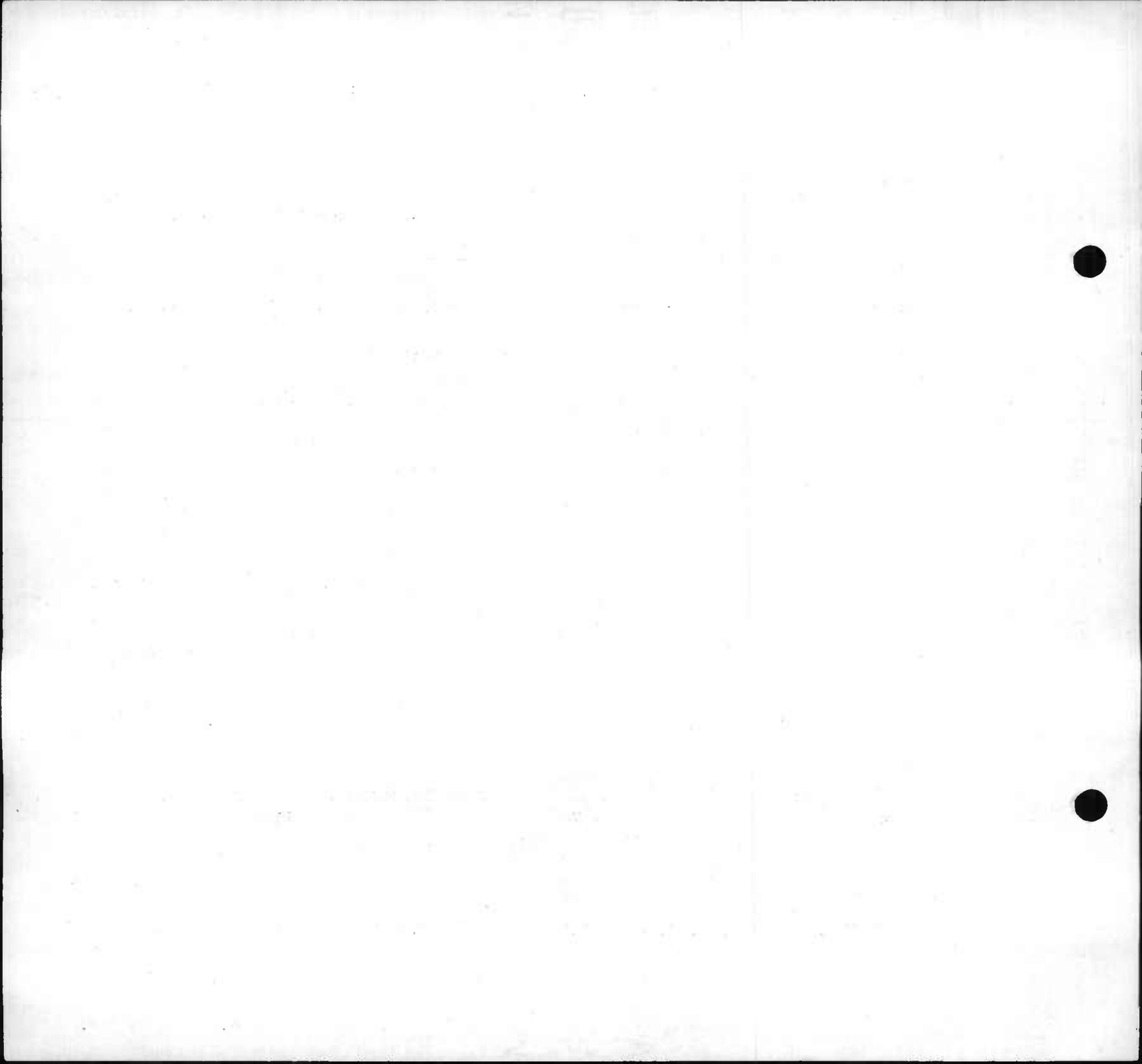
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2/20/71 - 2/20/71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

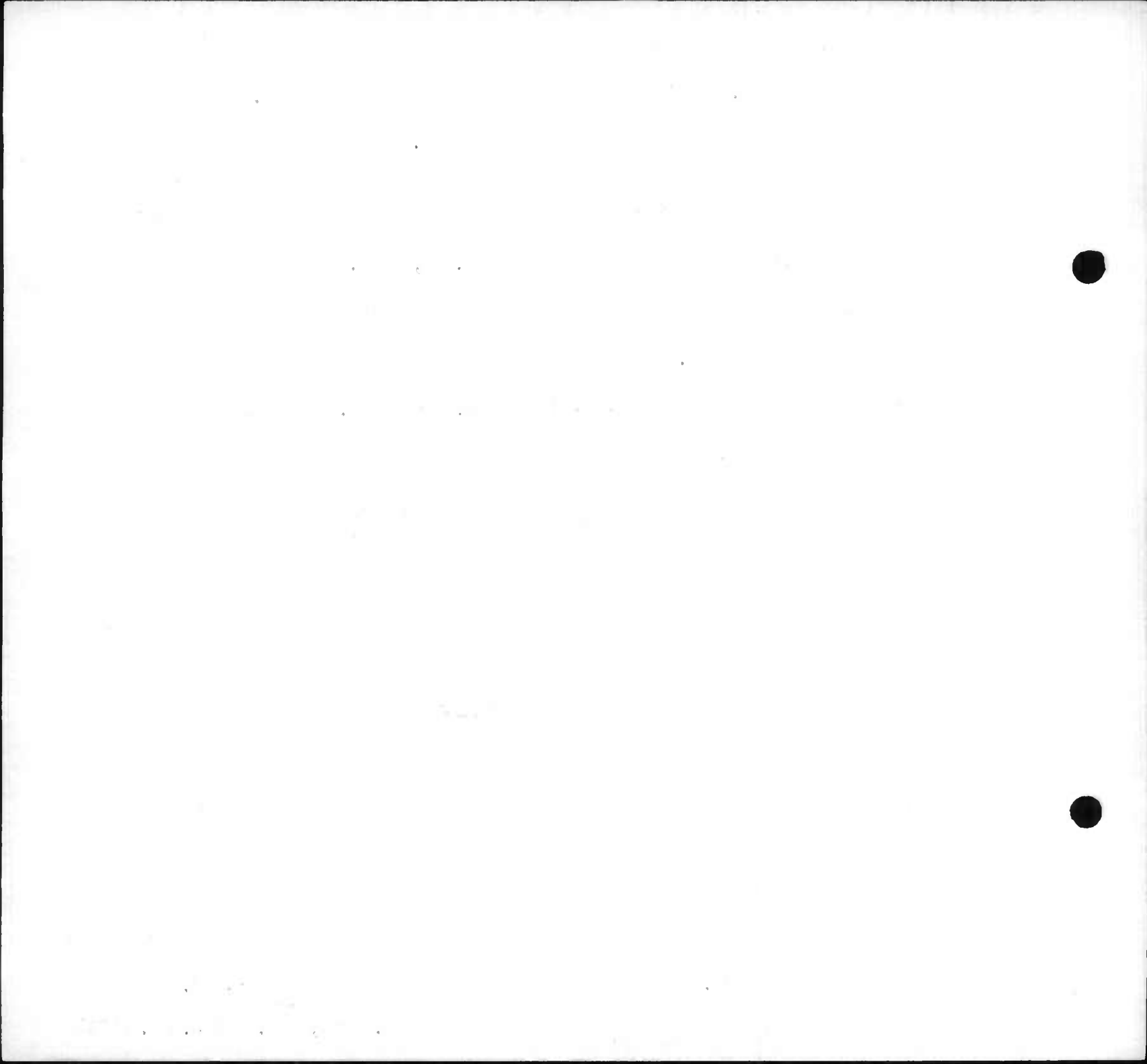
BALTIMORE CITY HEALTH DEPARTMENT										
CERTIFICATE OF DEATH										
REG. NO. 70 6876					70 6876					
BIRTH NO. <u>T-512</u> <u>70 6876</u>					DATE AND HOUR OF DEATH <u>3:05, July 8, 1970</u> <u>3:05</u> a. M.					
1. NAME OF DECEASED (Type or Print) <u>Steve Thompson</u>					2. DATE AND HOUR OF DEATH					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Ohio</u> B. COUNTY <u>V-32</u>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>U.S. Public Health Service Hospital</u> <u>3100 Wyman Park Drive</u>					C. CITY OR TOWN <u>Columbus</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER <u>341 N. Chesterfield Rd, Apt. 1</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-50</u>	9. AGE (In years last birthday) <u>19</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Battery repairman</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		
13. FATHER'S NAME <u>Richard Thompson</u>					14. MOTHER'S MAIDEN NAME <u>Christine Dow</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>233-80-5895</u>		17. INFORMANT ADDRESS <u>Records, USPHS Hospital, Baltimore, Md.</u>					
18. <u>15381</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>METASTATIC CARCINOMA OF COLON</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>METASTATIC CARCINOMA OF COLON</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
19A. DATE OF OPERATION <u>2</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that XX (this hospital) attended the deceased from <u>June 16, 1970</u> to <u>July 8, 1970</u> , that (X) (we) last saw the deceased alive on <u>July 8, 1970</u> and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (XXXX) view the body after death.										
23A. SIGNATURE <u>GARY E. FELDMAN, M.D.</u>					23B. DATE SIGNED <u>July 8, 1970</u>			23C. PHYSICIAN'S NAME (Type) <u>GARY E. FELDMAN, S. A. Surg (R)</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>7/11/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Wellman Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Salt Petre W. Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1970</u>					25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Young Funeral Home, Louisa Ky.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

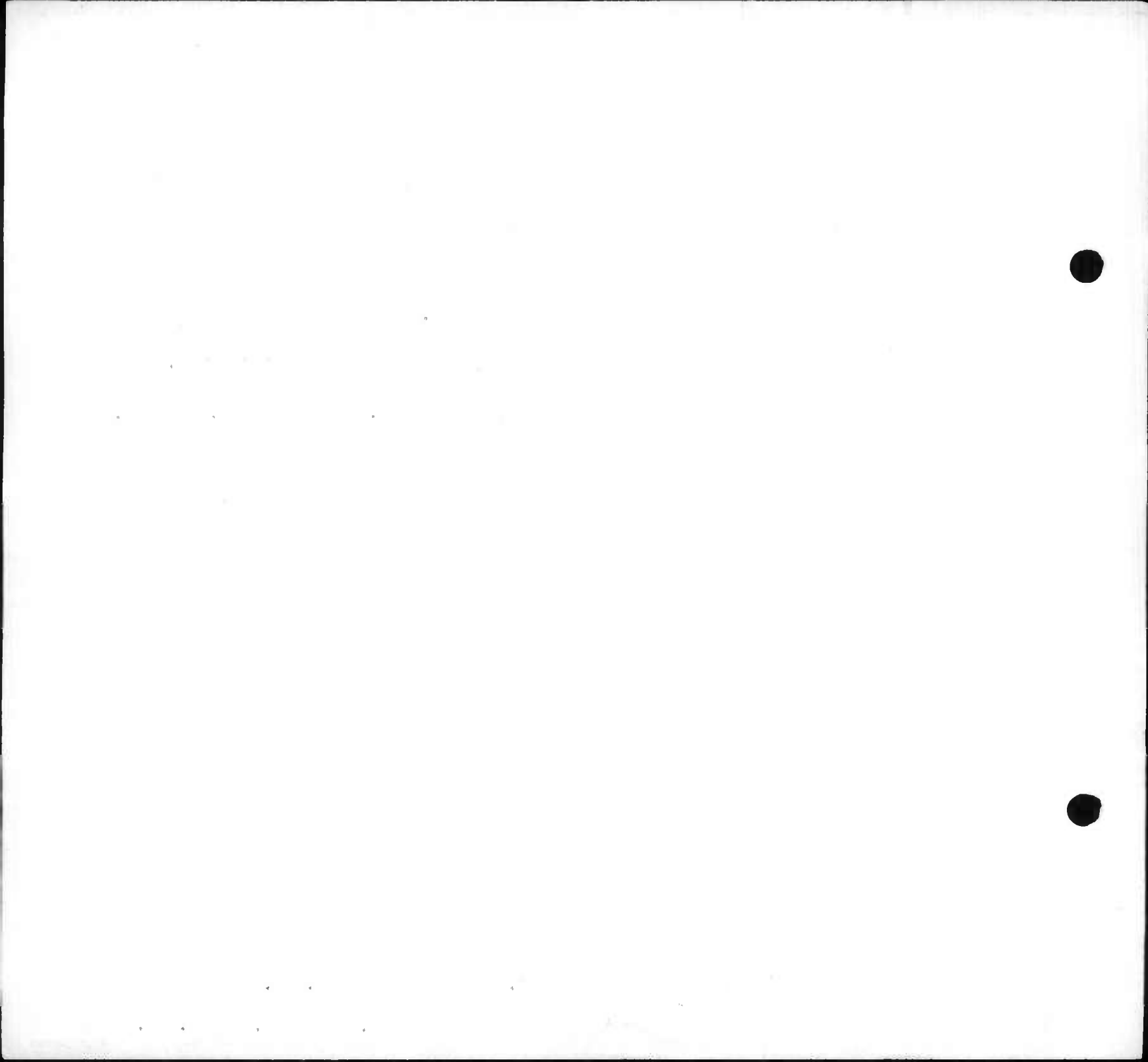
B-624 70 6877		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6877	
1. NAME OF DECEASED (Type or Print) Albert L. Borsella		2. DATE AND HOUR OF DEATH July 7, 1970. 9 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 4528 Harford Road		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2733			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5124 Harford Road			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1904.	9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME Francis X. Borsella		14. MOTHER'S MAIDEN NAME Vivian Landini			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-14-0959		17. INFORMANT Mrs. Theresa M. Borsella	
				ADDRESS (Same)	
18. 41017 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Acute coronary Occlusion (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: arteriosclerosis (B) cardio-vascular disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day - 1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 8 19 70 to July 7 19 70 that (I) (we) last saw the deceased alive on July 3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. J. Sawyer, Jr. M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/7/70	
23C. PHYSICIAN'S NAME (Type) G. J. SAWYER, JR. M.D.		23D. ADDRESS 4808 Harford Rd. Balto Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/70.		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Leonard J. Rutk, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BIRTH NO. M-200 70 6878</p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. 70 6878</p>					
<p>1. NAME OF DECEASED (Type or Print) Elsie R. McKay</p>			<p>2. DATE AND HOUR OF DEATH 7-7-70 9:25 A.M.</p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 401</p>		
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Key Circle Hospice 1214 Eutaw Place BALTIMORE, MARYLAND 21217</p>			<p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>		
<p>E. STREET AND NUMBER 311 Cathedral St.</p>					
<p>5. SEX Female</p>	<p>6. RACE White</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 4-27-84</p>	<p>9. AGE (In years last birthday) 86</p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) Md.</p>	
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>					
<p>13. FATHER'S NAME William S. McKay</p>			<p>14. MOTHER'S MAIDEN NAME Estelle F. McNeir</p>		
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>16. SOCIAL SECURITY NO. 214-54-6154-1</p>		<p>17. INFORMANT Wilbur S. McKay ADDRESS 3501 St. Paul St.</p>	
<p>18. CAUSE OF DEATH</p>					
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHF</p>			<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hd.</p>		
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. asevd</p>			<p>(B) DUE TO, OR AS A CONSEQUENCE OF: indefinitely</p>		
<p>(C)</p>			<p>(D)</p>		
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Brachy neurone</p>					
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) no</p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>					
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 7 Jul 27 1969 to 7 Jul 1970 that (I) (we) last saw the deceased alive on 7 Jul 1970 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE J. Hulla MD</p>			<p>23B. DATE SIGNED 7 Jul 70</p>		
<p>23C. PHYSICIAN'S NAME (Type) J. Hulla MD</p>			<p>23D. ADDRESS 2214 Eutaw Pl Baltimore 21231</p>		
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 7/10/70</p>		<p>24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.</p>	
<p>24D. LOCATION (City, town, or county) (State) Balto. Md.</p>					
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor MD</p>		<p>25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. ADDRESS Balto. Md.</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		70 6879		REG. NO. 70 6879	
BIRTH NO. <u>D-620</u>		70 6879			
1. NAME OF DECEASED (Type or Print) <u>Dorsey Elmer</u>		2. DATE AND HOUR OF DEATH <u>6:30 pm. 8 July 1970</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>200-3</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u> <u>2025 W. Fayette Street</u> <u>Balt. Md. 21223</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>638 S. Monroe St.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01/31/24</u>	9. AGE (In years last birthday) <u>43</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>McLean Truck Co</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Samuel Dorsey</u>			
14. MOTHER'S MAIDEN NAME <u>Thompson</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Ethel Johnson 638 S. Monroe St</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>78-2-1</u> <u>Cardiac Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>He</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>06-8-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7-1-70</u> 19 <u>78-70</u> 19 <u>7-8</u> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Cawee, M.D.</u>		23B. DATE SIGNED <u>7-8-70</u>		23C. PHYSICIAN'S NAME (Type) <u>George L. Schwab Jr.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-13-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Louper Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto City</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fahey, M.D.</u>		25C. FUNERAL DIRECTOR <u>George L. Schwab Jr.</u>			



M-460

70 6880

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 6880

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Janett Miller		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 7 5 70 10:55 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1828x 1738 E. Balton St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 5 70 10:55 a.m.	
6. SEX female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1401	
9. DATE OF BIRTH 11/13/18		10. AGE (In years last birthday) 43	
11. BIRTHPLACE (State or foreign country) Corker Co. Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cannie Stout		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Essie Woody		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 205-40-0400		18. INFORMANT Petrick Funeral Home	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/70	
24C. NAME OF CEMETERY or CREMATORY Richardson Cem.		24D. LOCATION (City, town, or county) (State) Carter Co. Tenn.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR W. S. Edwards, Inc.		25D. ADDRESS	

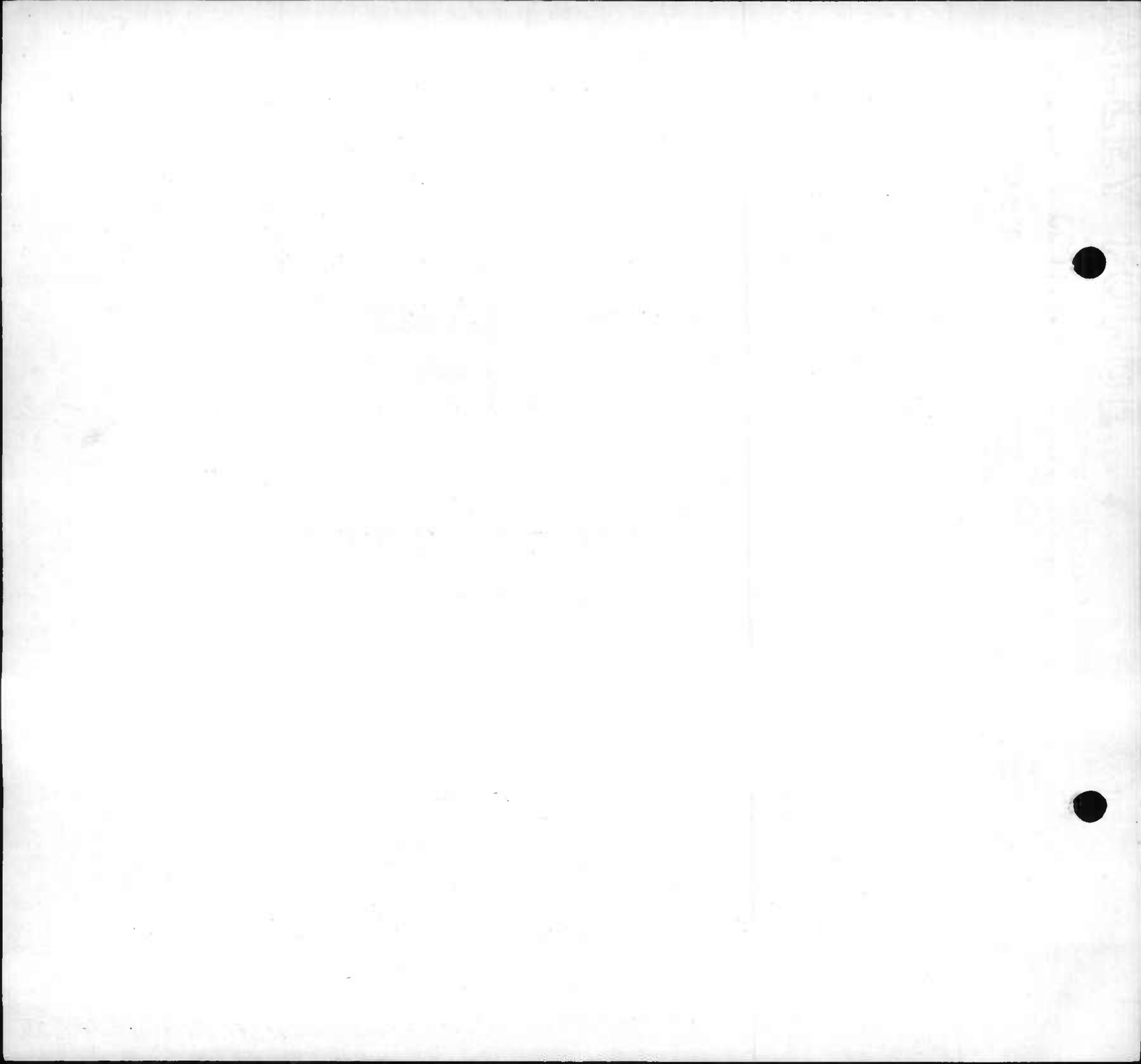
SE

Bolton st

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

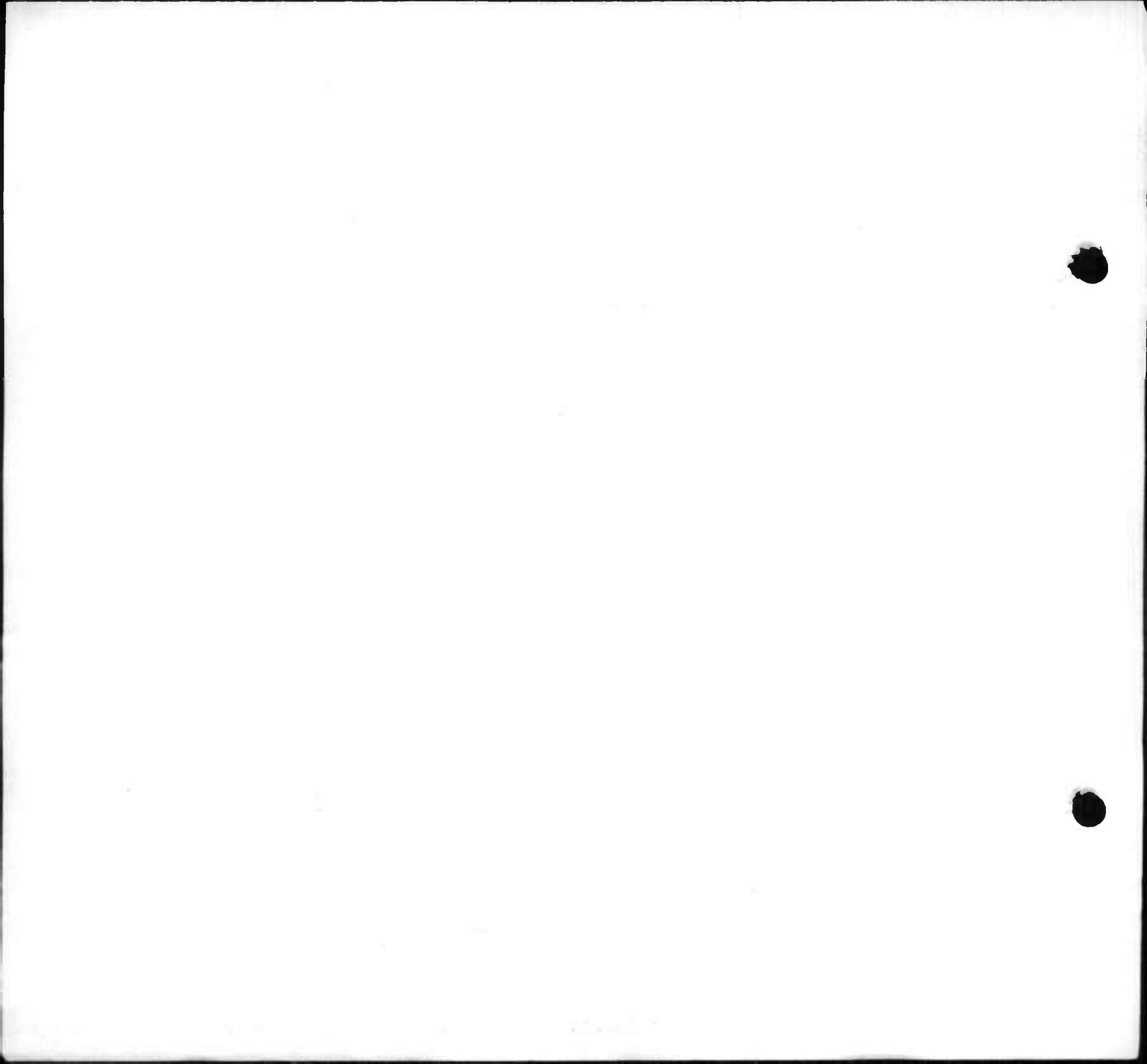
BALTIMORE CITY HEALTH DEPARTMENT									
70 6881 CERTIFICATE OF DEATH									
REG. NO. 70 6881									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) SERAFINA CZANKOWSKA					2. DATE AND HOUR OF DEATH JULY 7, 1970 11:30 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY 104				
FULL NAME OF HOSPITAL OR INSTITUTION 1807 S. PORT ST					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 807 S. PORT ST									
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 25 1914 75	9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS			10B. KIND OF BUSINESS OR INDUSTRY CLOTHING		11. BIRTHPLACE (State or foreign country) POLAND			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HILLARY KAMINSKI				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-09-5546		17. INFORMANT EDMUND C. CZANKOWSKI		ADDRESS 3112 EVERGREEN	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension Cardio-Vascular Disease					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 2, 1968 to June 24, 1970 , that (I) (we) lost saw the deceased alive on June 24, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Andrew Kunkowski, M.D.							23B. DATE SIGNED 7/9/70		
23C. PHYSICIAN'S NAME (Type) Andrew Kunkowski, M.D.							23D. ADDRESS 2529 Eastern Ave Balto, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 7-11-70		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEM.		24D. LOCATION (City, town, or county) (State) DUNDALK MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			25C. FUNERAL DIRECTOR ADDRESS JOHN M WEBER & SONS INC 401 S. CHESTER ST			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6882		REG. NO. 70 6882	
CERTIFICATE OF DEATH							
BIRTH NO. 70 6882				1. NAME OF DECEASED (Type or Print) ANNA PNIEWSKI			
2. DATE AND HOUR OF DEATH JULY 8 1970				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL BALTIMORE, MARYLAND 21231				A. STATE MARYLAND B. COUNTY 603			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 29 N. COLLINGTON AVE.							
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-19-16	9. AGE (In years last birthday) 53 yrs	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICA							
13. FATHER'S NAME MICHAEL ROSINSKI				14. MOTHER'S MAIDEN NAME MARY PRASIMOWICZ			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 212-42-6500		17. INFORMANT MR. JOSEPH PNIEWSKI ADDRESS 29 N. COLLINGTON AVE., BALTO., Md.	
18. 42741 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE CEREBROVASCULAR ACCIDENT			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) ATRIAL FIBRILLATION			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6/26 1970 to 7/8 1970 that (I) (we) last saw the deceased alive on 7/8 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A.C. Chouvalit, M.D.				23B. DATE SIGNED 7/8/70			
23C. PHYSICIAN'S NAME (Type) A.C. CHOUVALIT, M.D.				23D. ADDRESS CHURCH HOME & HOSPITAL BALTO., MD. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/11/70		24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY		24D. LOCATION (City, town, or county) DUNDALK MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR JOHN WERTER & SONS		ADDRESS 401 S. CHESTER	



1
W-534

BALTIMORE CITY HEALTH DEPARTMENT

70 6883

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6883

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Tracy G. Wendell WENDEL

2. DATE
OF
DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

CERTIFICATE AMENDED

Sinai Hospital 7-15-70

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

7 - 6 7 - 70

12:20 a

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

202

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

9. DATE OF BIRTH

June 3 1943

10. AGE (In years last birthday)

27

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

17 S Broadway

Box 5744 Koinonia Foundation

11. BIRTHPLACE (State or foreign country)

Tooele, Utah

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Clarence A. Wendell Wendel

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Social Worker

14B. KIND OF BUSINESS OR INDUSTRY

Social Services

15. MOTHER'S MAIDEN NAME

Helen D. Giller

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

215 42 5425

18. INFORMANT (Father) Wendell

ADDRESS

Clarence A. Wendell, American Embassy/USGS

APC 09676, N.Y.C., Rio de Janeiro, Brazil

19. 2957X

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE
Crushing of chest
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Koinonia Foundation

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY (APPROX.) 7 6 70 10:00 m.

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

apparently jumped from height

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

Deputy Chief Medical Examiner

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/7/70

24A. BURIAL CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

July 9 1970

24C. NAME OF CEMETERY or CREMATORY

Loudon Park Crematory

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 9 1970

25B. NAME OF REGISTRAR

Robert E. Fahey, M.D.

25C. FUNERAL DIRECTOR

Curtis E. Evans

ADDRESS

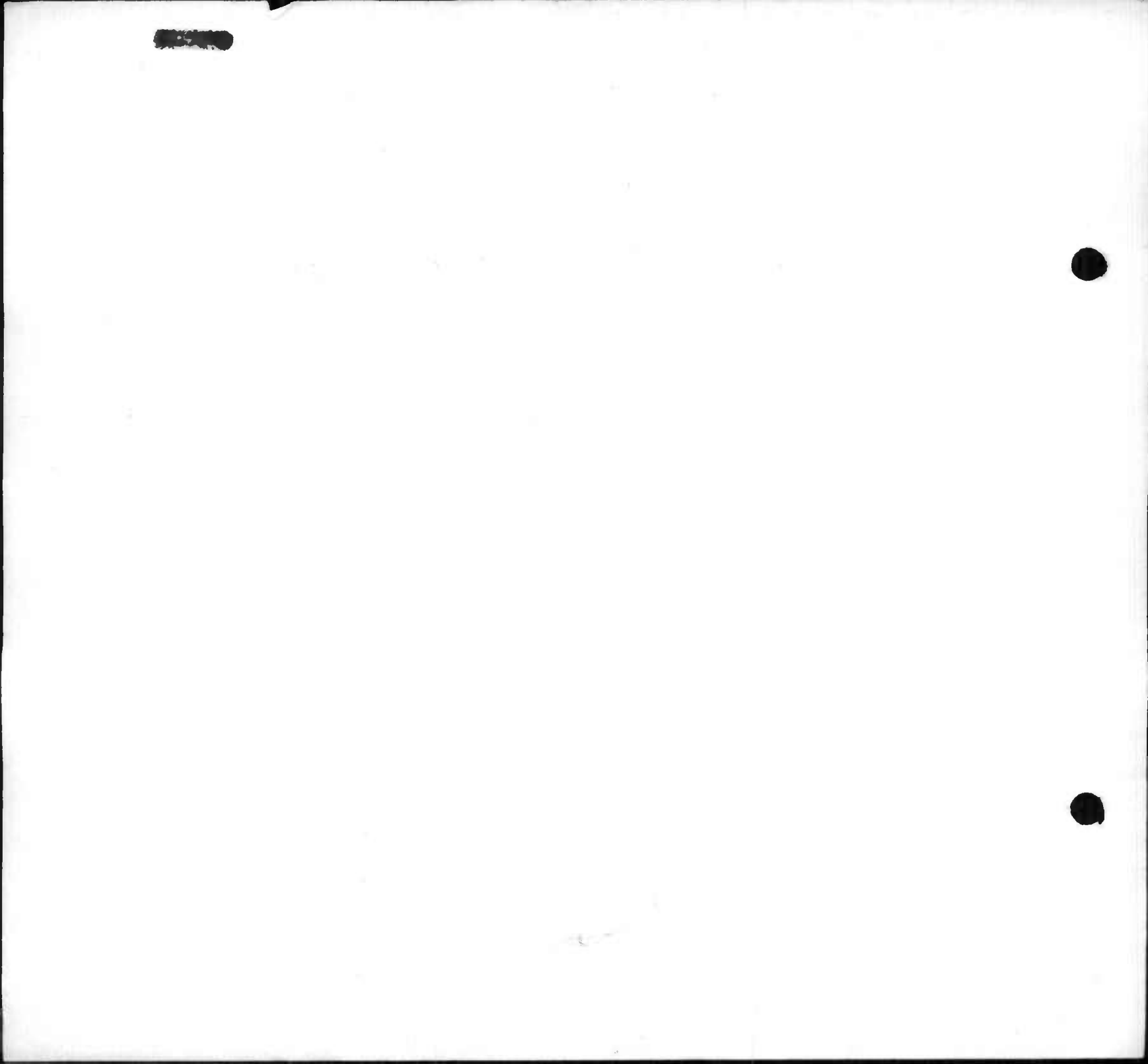
1400 S Charles St Balto Md 21230

Letter from M.E.'s office 7-15-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-362		70 6884		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6884	
1. NAME OF DECEASED (Type or Print) SAMUEL PETERSON				2. DATE AND HOUR OF DEATH 7-4-70 8-20 AM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Harbor View Nursing Home 1213 South Light St				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2301					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harbor View Nursing Home 1213 South Light St				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1432 W. Cross St				5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Work		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 7-4-05		9. AGE (In years last birthday) 65		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) No. Carolina				12. CITIZEN OF WHAT COUNTRY? U. S. A					
13. FATHER'S NAME Henry Peterson				14. MOTHER'S MAIDEN NAME Maggie					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 705-07-4085		17. INFORMANT Jennie Peterson ADDRESS 1432 W. Cross St			
18. 412.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. If means the disease, injury or complication which caused death.) Carbide Arter				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carmay Insufficiency				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V. Disease				(B) DUE TO, OR AS A CONSEQUENCE OF: C.V.A. - Hypertension				5/29/70	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Light. Hemiplegia									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6/9 1970 to 7/4 1970 that (I) (we) last saw the deceased alive on 6/24 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Joseph S. Blum				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/6/70			
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM				23D. ADDRESS 1115 N. CALVERT ST.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/70		24C. NAME OF CEMETERY or CREMATORY 4th Calvary		24D. LOCATION (City, town, or county) (State) Brooklyn, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles D. Rice ADDRESS 661 W. Baiter St.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; font-weight: bold;">M-420 70 6885</div>		<div style="font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-weight: bold;">CERTIFICATE OF DEATH</div>		<div style="font-weight: bold;">REG. NO. 70 6885</div>	
<div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) MLECZKO, Marion </div> <div> 2. DATE AND HOUR OF DEATH 7-1-70 at 7:30 a.m. </div> </div>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital, Baltimore, Maryland.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2610		
5. SEX M. 6. RACE American 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 11-28-24 9. AGE (In years last birthday) 45		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? American		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT MELVIN MLECZKO
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH carcinoma of lung with wide spread metastasis			ADDRESS 1802 Dunmore St. Rd., Balt., Md.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6-12-70 to 7-1-70 that (I) (we) last saw the deceased alive on 6-29-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Latha Hanna				23B. DATE SIGNED 7-1-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS ANATOMY BOARD OF MARYLAND JOHNS HOPKINS MEDICAL SCHOOL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7-9-70		24C. NAME of CEMETERY or CREMATION	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO	



THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

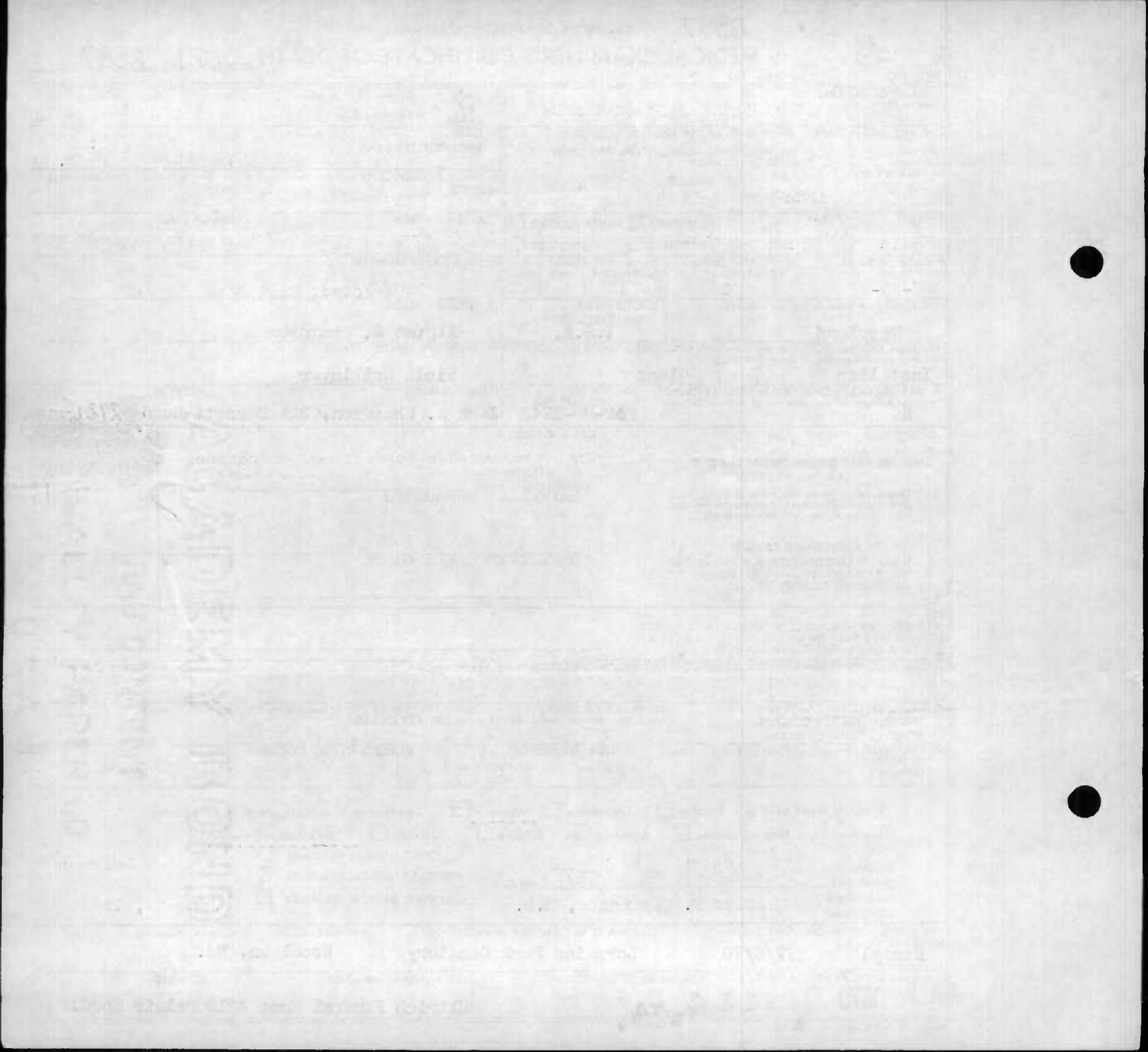
1

BIRTH NO. W-62370		6886		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70		6886	
1. NAME OF DECEASED (Type or Print) WRIGHTSON Phyllis						2. DATE OF DEATH 24 May 70			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00723 So. Bond St.						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland COUNTY 203 C. CITY OR TOWN Baltimore (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 723 S. Bond St 21731			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1901	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10s. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME Montague						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. 179 017365			17. INFORMANT ADDRESS			
18. 713.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertension ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Osteoarthritis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) Hypertension DUE TO (B) Osteoarthritis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH several yrs " "	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II			19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 24 May 1970 to 24 May 1970 , that (I) (we) last saw the deceased alive on 24 May 1970 , and that in (my) (our) opinion death occurred at 7:20 A.M. , from the causes and on the date stated above.									
23a. SIGNATURE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D. J. Kulla MD			23b. ADDRESS 3224 E. Carroll St			23c. DATE SIGNED 18 Jun 70			
24a. BURIAL, CREMATION, REMOVAL (Specify)			24b. DATE 7-7-70		24c. NAME OF CEMETERY OR CREMATION ANATOMY BOARD OF MARYLAND				
25a. DATE REC'D BY HEALTH DEPT. JUL 9 1970			25b. NAME OF REGISTRAR Robert E. Taylor		25c. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL				
25d. MORTUARY SERVICE - BCHO									

109700006871

RECEIVED
1907

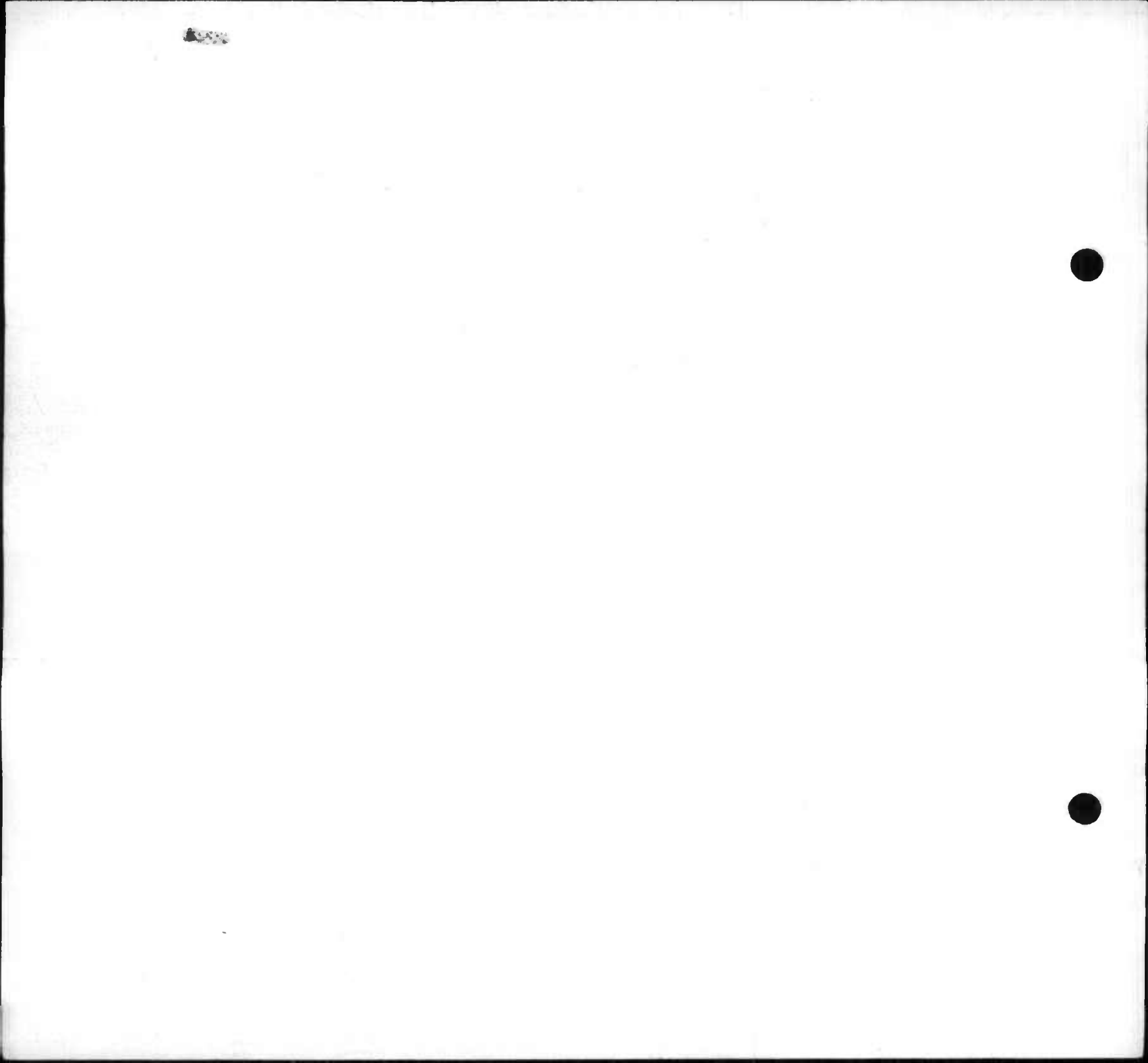
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 70 6887	
1. NAME OF DECEASED (Type or Print) SAMUEL ERNEST CHAUDRON				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input checked="" type="checkbox"/> 1950		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lake Montebello				3. DATE PRONOUNCED DEAD Month Day Year June 10, 1970		Hour 11:55 A. M.	
6. SEX Male				7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 7-29-07				10. AGE (In years last birthday) 62		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME August A. Chaudron		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Installer	
15. MOTHER'S MAIDEN NAME Viola Waltemyer				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 202-03-1742	
18. INFORMANT Jack A. Chaudron, 6821 Barnett Road				19. ADDRESS 21212		20. CAUSE OF DEATH Undetermined due to post mortem changes	
21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
24. DATE OF OPERATION 2				25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) Yes	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
30. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 7/8/70				31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED June 29, 1970							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/8/70		24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.				25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970		25B. NAME OF REGISTRAR Robert E. Fisher	
25C. FUNERAL DIRECTOR Ullrich Funeral Home				25D. ADDRESS 4210 Belair Road.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

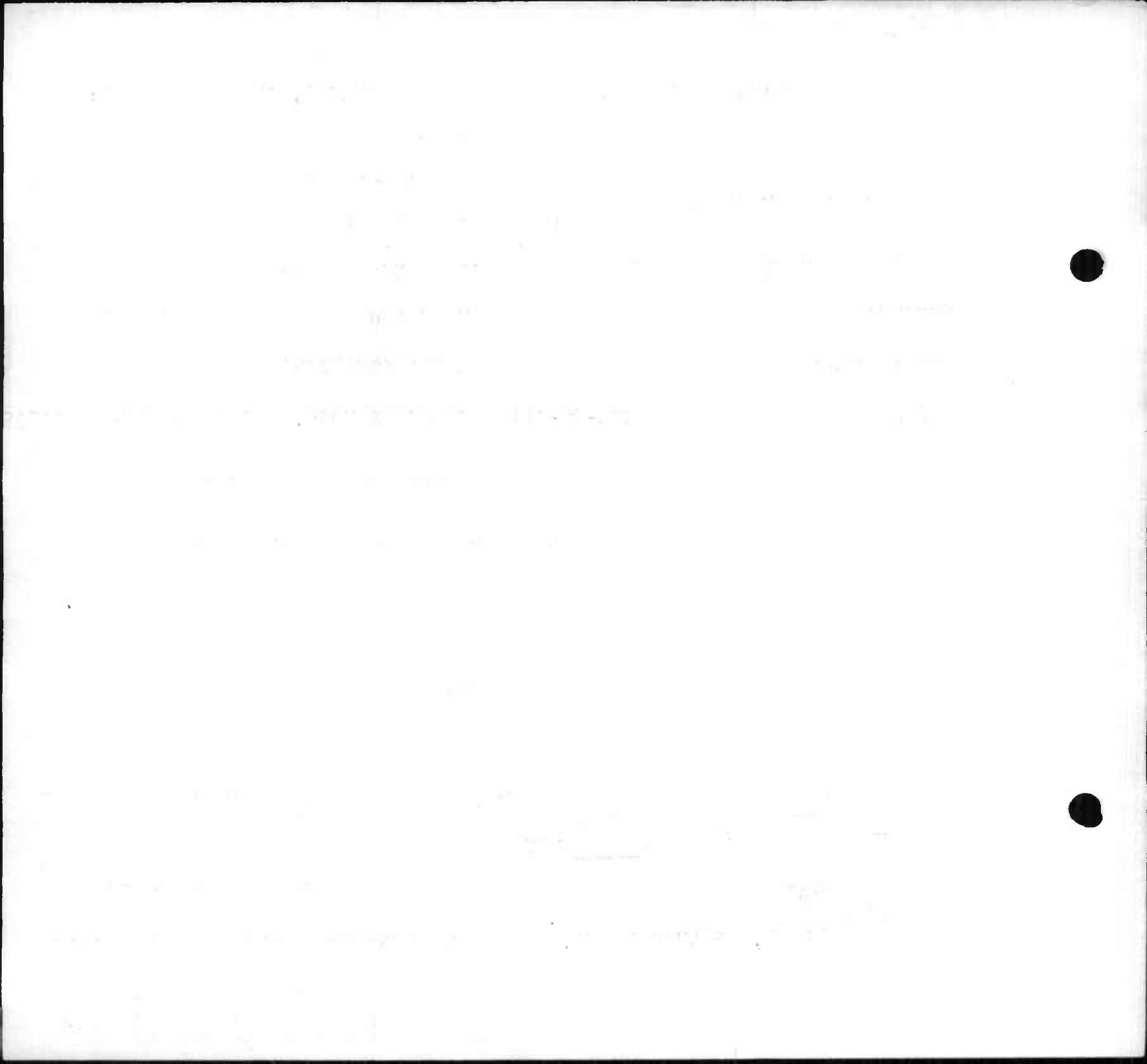
B-520		70 6888		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 70 6888	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>BUNAS Anna</u>					
2. DATE AND HOUR OF DEATH <u>7/5/70 @ 9:30pm</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1213 Light St. Balto Md. 21230</u> <u>Harbor View N.C.C.</u>					
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Harford</u> C. CITY OR TOWN <u>Balto Md</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>602</u>				5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH <u>7/2</u> 9. AGE (In years last birthday) <u>70?</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.				10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>					
11. BIRTHPLACE (State or foreign country) <u>Greece</u> 12. CITIZEN OF WHAT COUNTRY? <u>—</u>				13. FATHER'S NAME <u>Thomas Bunas (D)</u> 14. MOTHER'S MAIDEN NAME <u>—</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Ladies Philoptochos Society</u> ADDRESS <u>520 S. Ponca St., Baltimore</u> <u>"St. Nicholas"</u>					
18. <u>4/12/41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cardiac Arrest</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
ANTECEDENT CAUSES <u>—</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>—</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.C.V. Disease</u>					
(B) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF: <u>—</u>				(C) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF: <u>—</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Senility</u>									
19A. DATE OF OPERATION <u>7/6/70</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> 20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>—</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u> 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <u>—</u>									
22. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> 19 <u>69</u> to <u>6/28</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>6/28</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Joseph S. Blum</u> 23B. DATE SIGNED <u>7/6/70</u> 23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM</u> 23D. ADDRESS <u>1115 N. CALVERT ST</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>7-8-70</u> 24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u> 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>									
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 9 1970</u> 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> 25C. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u> ADDRESS <u>3021 Eastern Ave., Baltimore, Md.</u>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

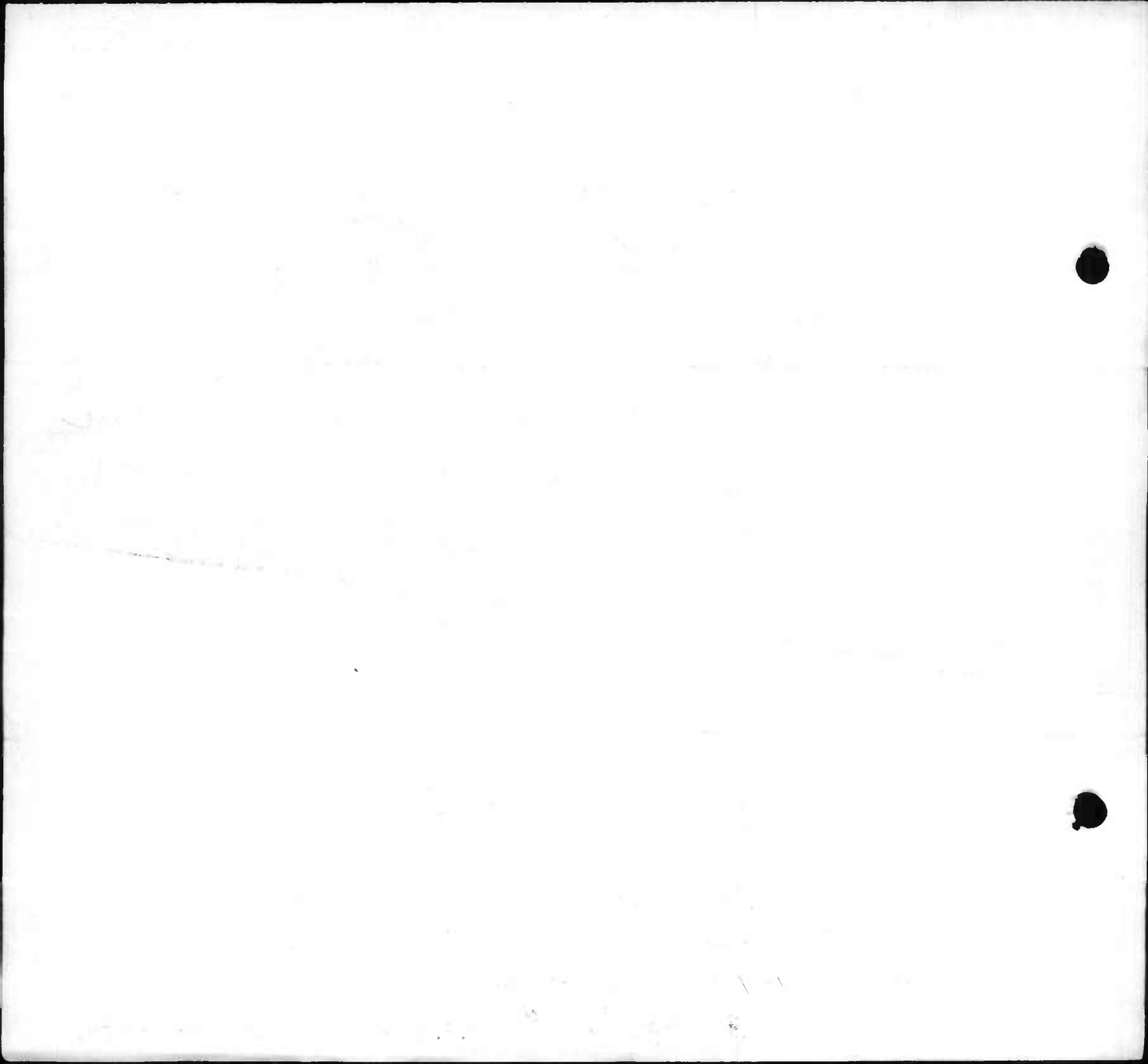
M-200 70 6889		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X	REG. NO. 70 6889	
1. NAME OF DECEASED (Type or Print) MCKAY, MARY LILLIAN				2. DATE AND HOUR OF DEATH JULY 6, 1970 3:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore 5300 C. CITY OR TOWN BALTIMORE Arbutus D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1808 ARBUTUS AVENUE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 97 12 02 00	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME EDWIN RING			14. MOTHER'S MAIDEN NAME LAURA (SMARDON)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579-09-1226		17. INFORMANT ST AGNES HOSP. RECORDS BALTO MD 21229		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
22. I certify that (X) (this hospital) attended the deceased from JUNE 29 1970 to JULY 6 1970 that (X) (we) last saw the deceased alive on JULY 6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.						
23A. SIGNATURE 				23B. DATE SIGNED 07 06 70		23C. PHYSICIAN'S NAME (Type) QUIROZ, SALVADOR MD.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/9/70		24C. NAME OF CEMETERY or CREMATORY Landon Park Cemetery
24D. LOCATION Baltimore, Maryland				24E. NAME OF REGISTRAR John E. ...		24F. FUNERAL DIRECTOR Anthony ...
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970				25B. NAME OF REGISTRAR John E. ...		25C. FUNERAL DIRECTOR Anthony ...



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

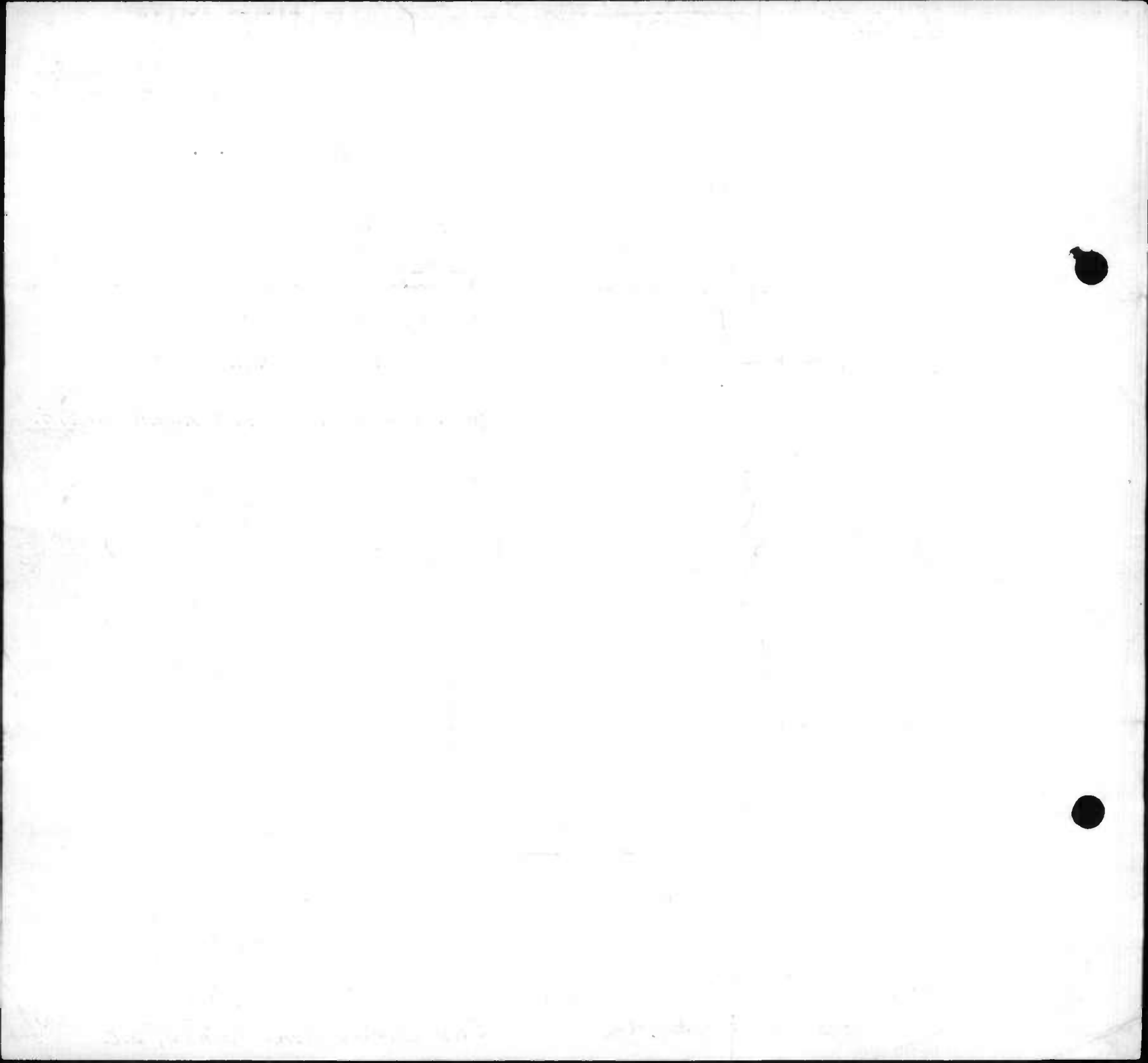
BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.	
G-520 70 6890		70 6890		70 6890	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GONCE, BERTHA E.		2. DATE AND HOUR OF DEATH July 7th 1970 1245/P	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN	
FULL NAME OF HOSPITAL OR INSTITUTION NORTH CHARLES GEN. HOSPITAL		A. STATE MD		B. COUNTY BALTO.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3014 PUTTY HILL AVE.		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. SEX FEMALE		9. DATE OF BIRTH 11 10 84		10. AGE (In years last birthday) 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George B. Claitice		14. MOTHER'S MAIDEN NAME Mary Brady		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-54-8941		17. INFORMANT My B. Hickey (daughter)	
18. 436.71		19. CAUSE OF DEATH		ADDRESS same	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA - Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Severe emphysema, electrolyte imbalance DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 2nd 1970 to July 7th 1970 and that (I) (we) last saw the deceased alive on July 7th 1970 and that in (my) (our) opinion death occurred on the date one hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sam C. Pappas		23B. DATE SIGNED 7/7/70		23C. PHYSICIAN'S NAME (Type) S. PAPPAS, M.D.	
23D. ADDRESS North Charles Hospital, BALTO, Md		24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7/10/70	
24C. NAME OF CEMETERY OR CREMATORY Mount Maria Cem.		24D. LOCATION Towson		24E. (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR C.F. EVANS & SON	
				ADDRESS 8802 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

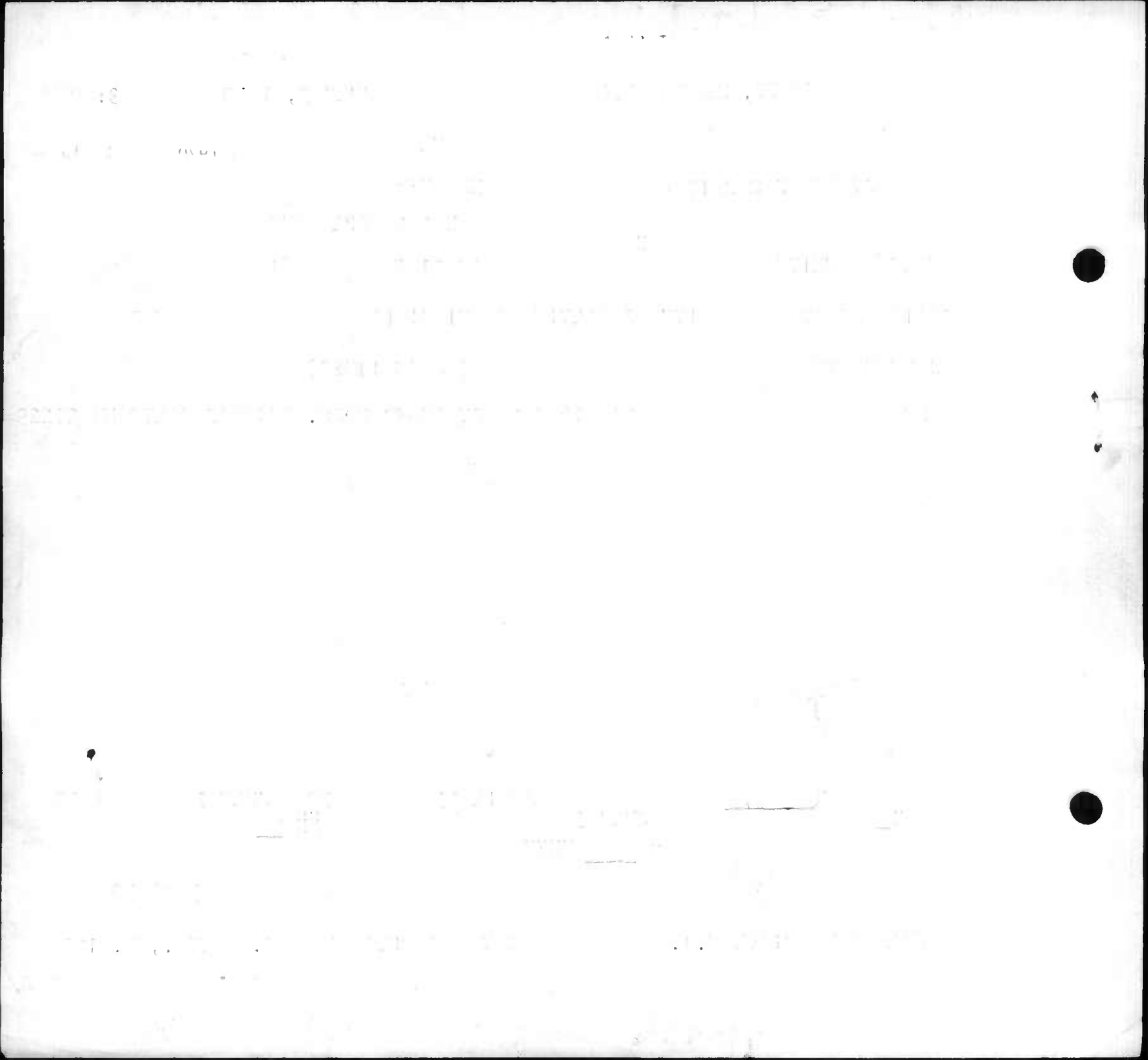
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>4-535 70 6891 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>X HINTON, SHELIA</p> <p>REG. NO. 47</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) SHELIA HINTON</p>		<p>2. DATE AND HOUR OF DEATH July 4, 1970 17:50 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE D.C. B. COUNTY V-48</p> <p>C. CITY OR TOWN WASHINGTON D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 607 Q STREET</p>	
<p>5. SEX FEMALE</p>	<p>6. RACE NEGRO</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 11-08-47</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>9. AGE (In years last birthday) 22</p>
<p>13. FATHER'S NAME EDERSON EDDISON WILLIS</p>		<p>14. MOTHER'S MAIDEN NAME MARY WASHINGTON</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT ADDRESS EDERSON R. Willis - 3307 Nichols Ave S.E.</p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;">CAUSE OF DEATH</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>(A) IMMEDIATE CAUSE Cerebral Edema DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Diabetic Ketoacidosis DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (the hospital) attended the deceased from 7/1/70 to 7-4-70 that (I) (we) last saw the deceased alive on 7-4-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>Joseph O. Moore</i></p>		<p>23B. DATE SIGNED 7/4/70</p>	
<p>23C. PHYSICIAN'S NAME (Type) Joseph O. Moore</p>		<p>23D. ADDRESS Johns Hopkins Hospital</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 7/11/70</p>	<p>24C. NAME OF CEMETERY OR CREMATORY HARMONY MEM PARK</p>	<p>24D. LOCATION (City, town, or county) (State) Landover, MD.</p>
<p>25A. DATE REC'D BY HEALTH DEPT. JUL 9 1970</p>	<p>25B. NAME OF REGISTRAR Robert E. Taber, M.D.</p>	<p>25C. FUNERAL DIRECTOR ADDRESS SAM Butler Inc. 3900 G.O. Ave N.W. WASH, D.C.</p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-530		70 6892		BALTIMORE CITY HEALTH DEPARTMENT		X		70 6892	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.			
		KNOTT, HERMAN OLEN		JULY 3, 1970		3:00PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL				A. STATE MARYLAND				B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN HANOVER				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER BOX 282 MAPLE AVE					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 21 08	9. AGE (In years last birthday) 61	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 1 Yr. Hours	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRAIN OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY CITY OF BALTIMORE		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME JOHN KNOTT				14. MOTHER'S MAIDEN NAME EDNA (GRINNES)					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219 14 0927		17. INFORMANT ST AGNES HOSP. RECORDS BALTO MD 21229		ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Left Lung Abscess DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Left intertrochanteric fracture									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from APRIL 23 1970 to JULY 3 1970 that (1) (we) last saw the deceased alive on JULY 3 1970 and that (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (X) (not) view the body after death.									
23A. SIGNATURE [Signature]				23B. DATE SIGNED 07 04 70					
23C. PHYSICIAN'S NAME (Type) SALVADOR QUIROZ M.D.				23D. ADDRESS Caton & Wilkens Aves. Balto. MD 21229					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		7-7-70		Cedar Hill Cemetery		Ritchie Highway		Balt Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
JUL 9 1970		Robert E. [Signature]		[Signature]		[Signature]			



H-435 **70-07352** **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. _____

BIRTH NO. _____

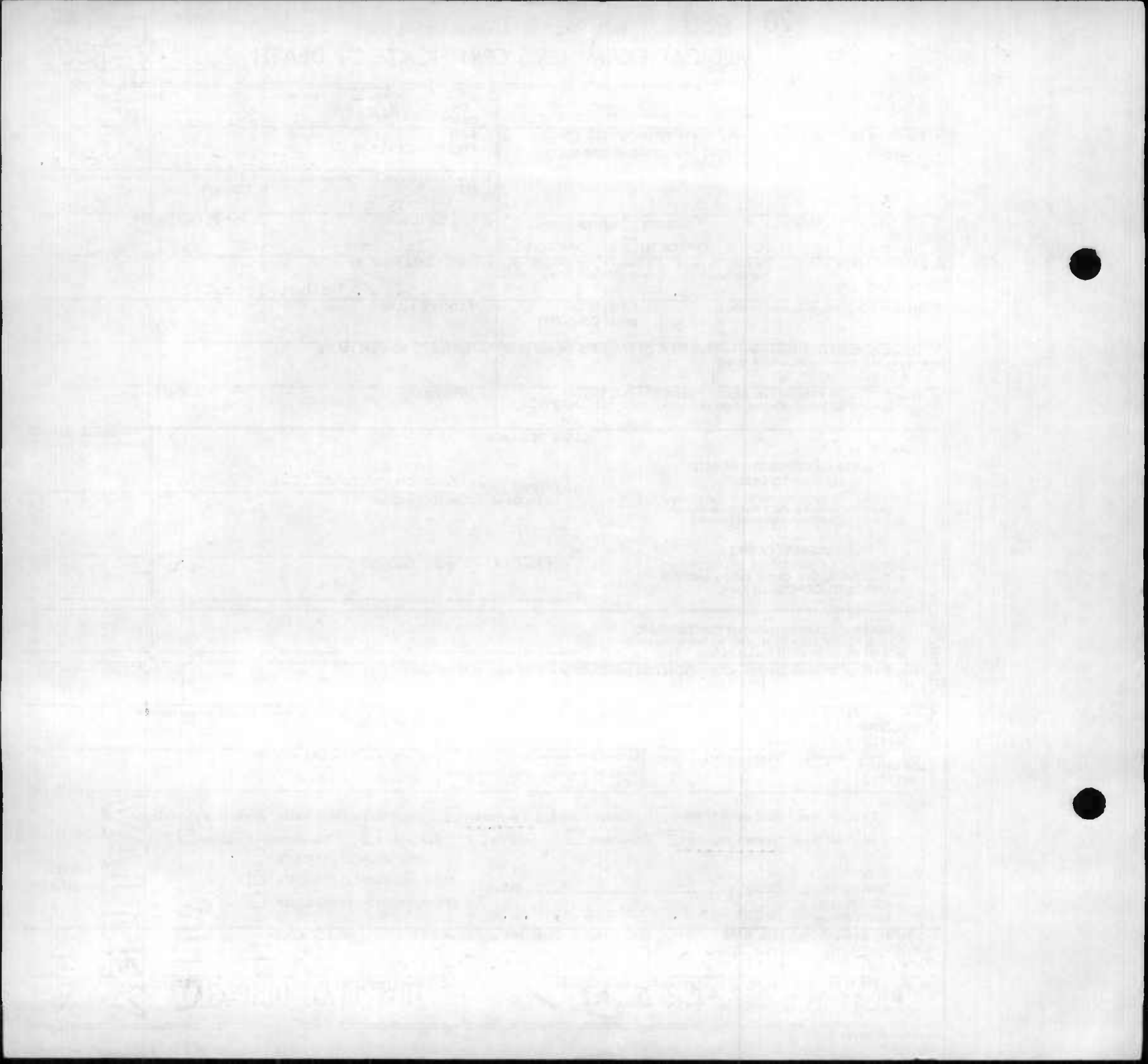
1. NAME OF DECEASED (Type or Print) BABY GIRL HELTON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour April 16, 1970 11:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour April 16, 1970 11:15 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday)		E. STREET AND NUMBER 3111 Elm Avenue	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. E 904 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Prematurity DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Inattention at birth		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? Florence Critterton Home - W. 32nd St.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-16-70 9:30 A.M.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Infant born and placed in wastebasket	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 26, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATED		24B. DATE 7-7-70	
24C. NAME OF CEMETERY or CREMATORY Medical Ex. Office		24D. LOCATION (City, town, or county) (State) 9801 to Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6894

BIRTH NO. 69-24161

1. NAME OF DECEASED (Type or Print) TYLON ANDREW SCHIVERS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> April 22, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 22, 1970 7:15 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years last birthday) 4 mths.		E. STREET AND NUMBER 1616 N. Bethel Street	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Calvin Schivers		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Cooper		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH 486X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute pneumonitis			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> April 23, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 7-7-70	
24C. NAME OF CEMETERY or CREMATORY Medical Ex. Office		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

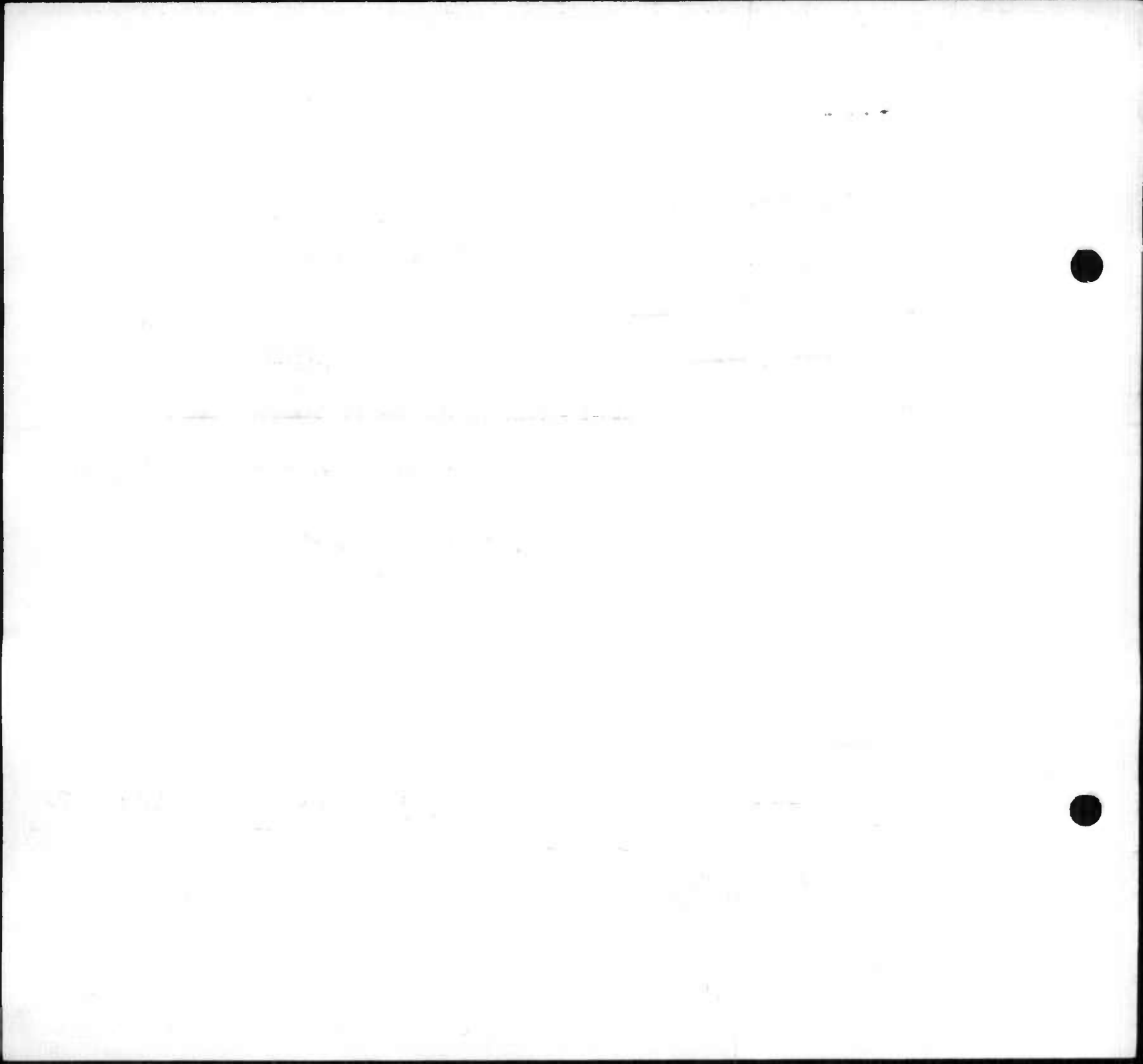
REG. NO. **70 6895**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAISY JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 520 N. Fremont		3. DATE PRONOUNCED DEAD Month Day Year Hour July 9, 1970 8:50 A. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1601	
9. DATE OF BIRTH UNK		10. AGE (in years last birthday) 71? If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. STREET AND NUMBER 520 N. Fremont	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT William J. Jones ADDRESS 3302 W. North Ave	
19. 441.21 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MASSIVE RETROPERITONEAL HEMORRHAGE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Ruptured abdominal aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) (Partial)		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-9-70	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 7/13/70	
24C. NAME OF CEMETERY or CREMATORY mt Calvary		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR William J. Jones		ADDRESS 3302 W. North Ave	

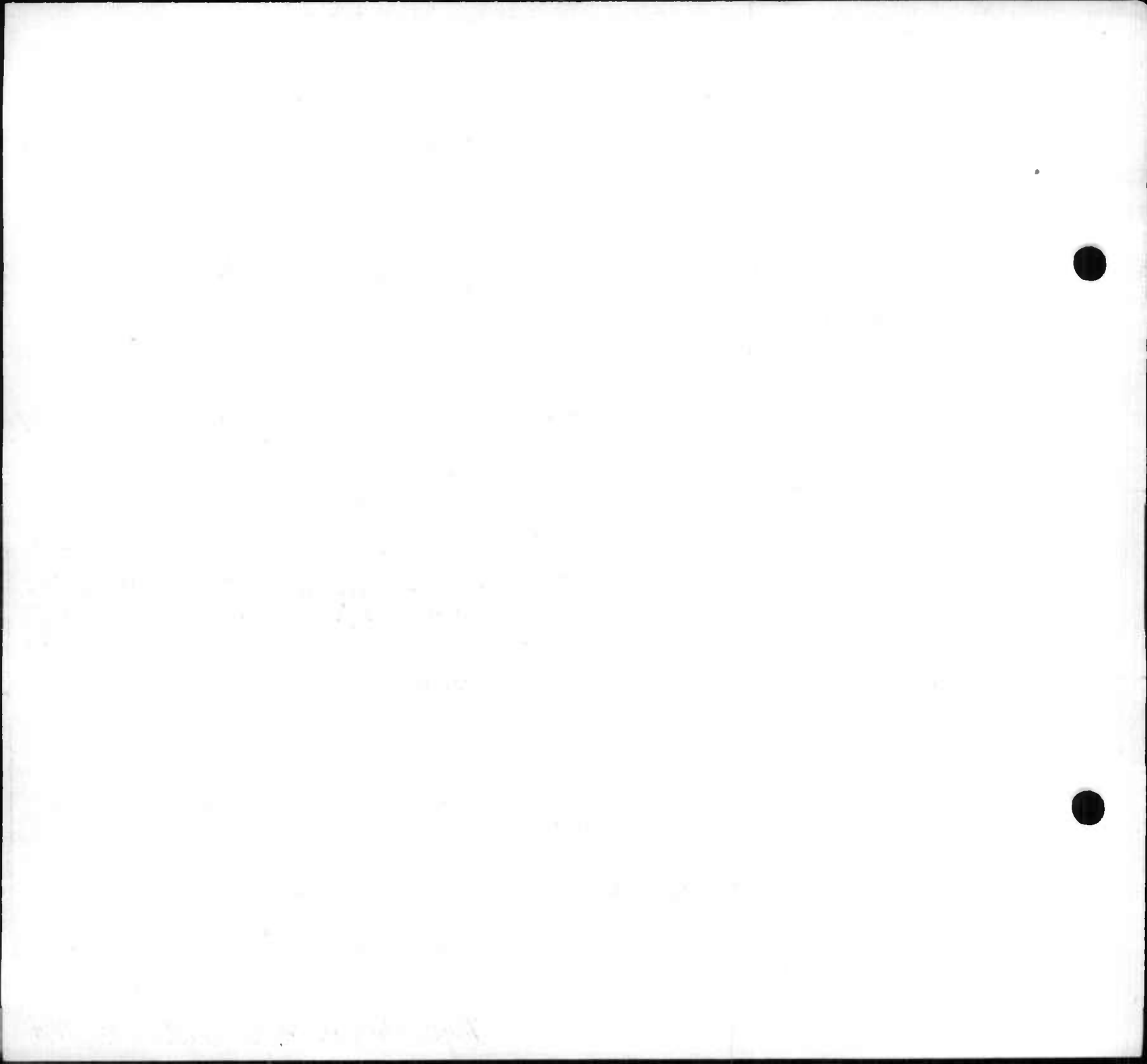
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-256		70 6896		BALTIMORE CITY HEALTH DEPARTMENT		70 6896	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Marie Wagner				2. DATE AND HOUR OF DEATH July 7, 1970 2:00 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2802			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5104 Oaklawn Road Baltimore, Maryland 21207				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4203 Maine Avenue 21207							
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 16, 1895	9. AGE (in years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank L. Pranke				14. MOTHER'S MAIDEN NAME Augusta Sinclair			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-0795A		17. INFORMANT ADDRESS Dorothy Rae 706 Stamford Road 21229			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years	
(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cerebral Disease				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 10/10 1955 to 7/7 1970 that (I) (we) last saw the deceased alive on 6/30 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Edwin L. Pierpont, M.D.				23B. DATE SIGNED 7/7/70		23C. PHYSICIAN'S NAME (Type) Edwin L. Pierpont	
23D. ADDRESS 8204 Liberty Road				23E. FUNERAL DIRECTOR Doring Byers Randallstown, Maryland 2113			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE July 10, '70		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Doring Byers Randallstown, Maryland 2113			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. <u>70 6897</u></p>	
<p>BIRTH NO. <u>K-520</u></p>		<p>DATE AND HOUR OF DEATH <u>4 July 70</u> <u>4</u> <u>PM</u></p>	
<p>1. NAME OF DECEASED (Type or Print) <u>Paul Dean Kuhns</u></p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland</u> <u>38 Hospital</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> C. CITY OR TOWN <u>Westminster</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>96 W. Green St.</u></p>	
<p>5. SEX <u>male</u></p>	<p>6. RACE <u>white</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Aug 19, 1927</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>draftsman</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>13. FATHER'S NAME <u>Paul F Kuhns</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Helen Davis</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>212-24-6036</u></p>	
<p>17. INFORMANT</p>		<p>ADDRESS</p>	
<p><u>PAUL F. KUHN</u></p>		<p><u>96 W. GREEN ST.</u> <u>WESTMINSTER, MD. 21157</u></p>	
<p>18. CAUSE OF DEATH</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Massive Upper Gastrointestinal Hemorrhage</u></p>		<p><u>20 min</u></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>renal failure</u></p>	
<p>(B) <u>transverse myelitis C4</u></p>		<p><u>4 months</u></p>	
<p>(C) <u>Candida septicemia</u></p>		<p><u>4 months</u></p>	
<p>(D) <u>respiratory failure</u></p>		<p><u>4 1/2 months</u></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <u>25 Feb 70</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Uremia</u></p>	
<p>20A. AUTOPSY? (Yes or No) <u>yes</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>1 July</u> 19 <u>70</u> to <u>4 July</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>4 July</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>David W. Fricke MD</u></p>		<p>23B. DATE SIGNED <u>4 July 1970</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>David W. Fricke</u></p>		<p>23D. ADDRESS <u>Center for Study of Trauma</u> <u>Univ. of Maryland Hosp Baltimore Md</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>	<p>24B. DATE <u>7/7/70</u></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <u>KNIDERS CEMETERY</u></p>	<p>24D. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MD</u></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1970</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u></p>	
<p>25C. FUNERAL DIRECTOR</p>		<p>ADDRESS</p>	
<p><u>Myers Funeral Home</u></p>		<p><u>Westminster, Md.</u></p>	



p-536

70

6898

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70

6898

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JAMES M. PONTIER

2. DATE
OF
DEATHKnown ☐
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3404 Park Heights Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

July 2, 1970

12:20 P.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1512

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

August 13, 1921

10. AGE (In years
last birthday)

54.80

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3404 Park Heights Avenue

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry G. Pontier

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Nellie

VonHolton

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

220-05-4667

18. INFORMANT

ADDRESS

Chester Pontier 2219 Walshire Ave. Balto. Md.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Epilepsy

"Acute Ethylism".

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Fatty metamorphosis of liver

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/3/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7/7/70

24C. NAME of CEMETERY or CREMATORY

Prospect Hill Cemetery

24D. LOCATION

(City, town, or county)

(State)

Towson, Baltimore Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 10 1970

25B. NAME OF REGISTRAR

Robert E. Gabley, M.D.

25C. FUNERAL DIRECTOR

Laurel Funeral Home Inc. 550 Washington Blvd

ADDRESS

Howard M. Fleck

Laurel, Md. 20810

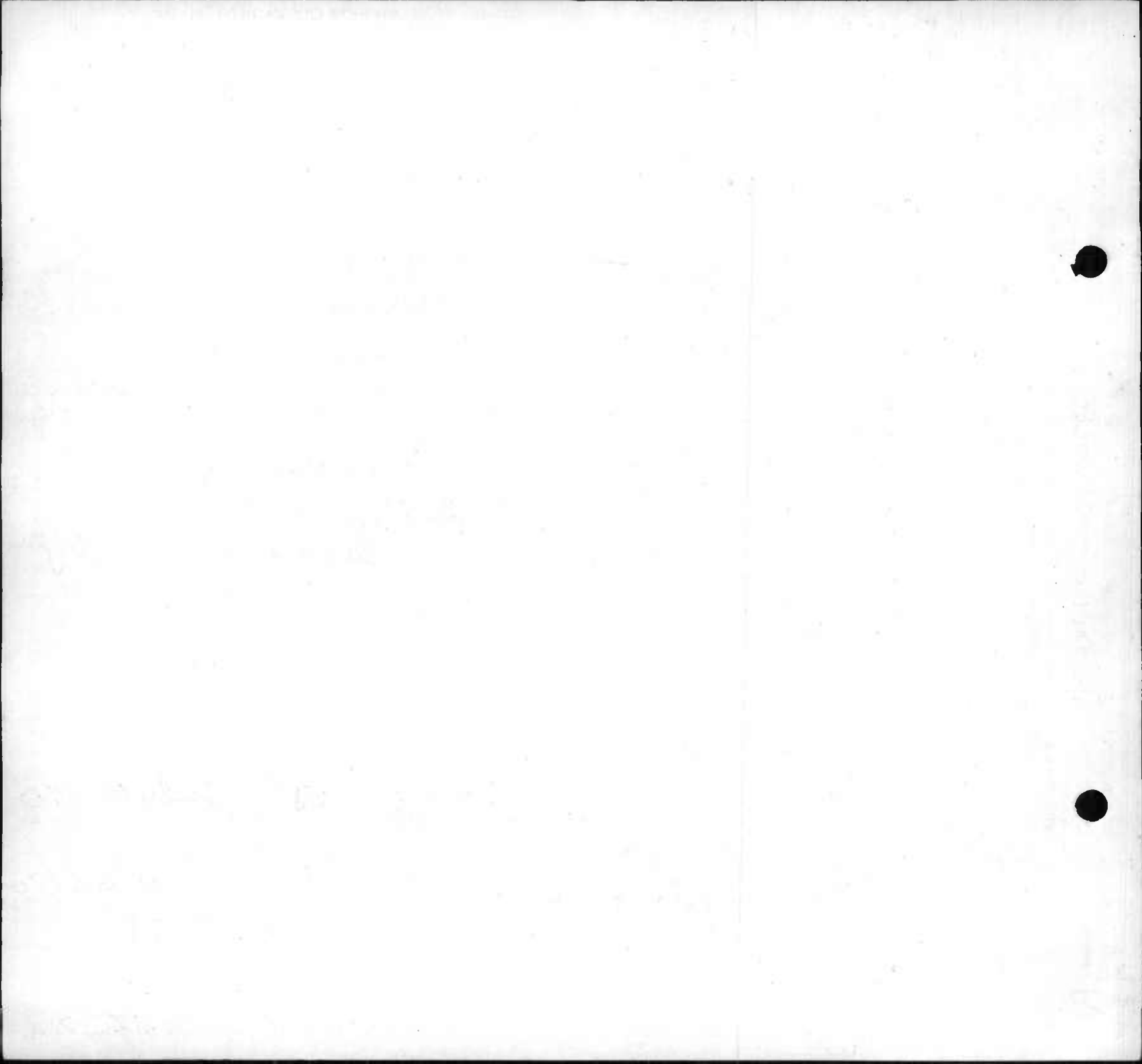
7/10/70 - Letter from Assistant Medical Examiner.

APC.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

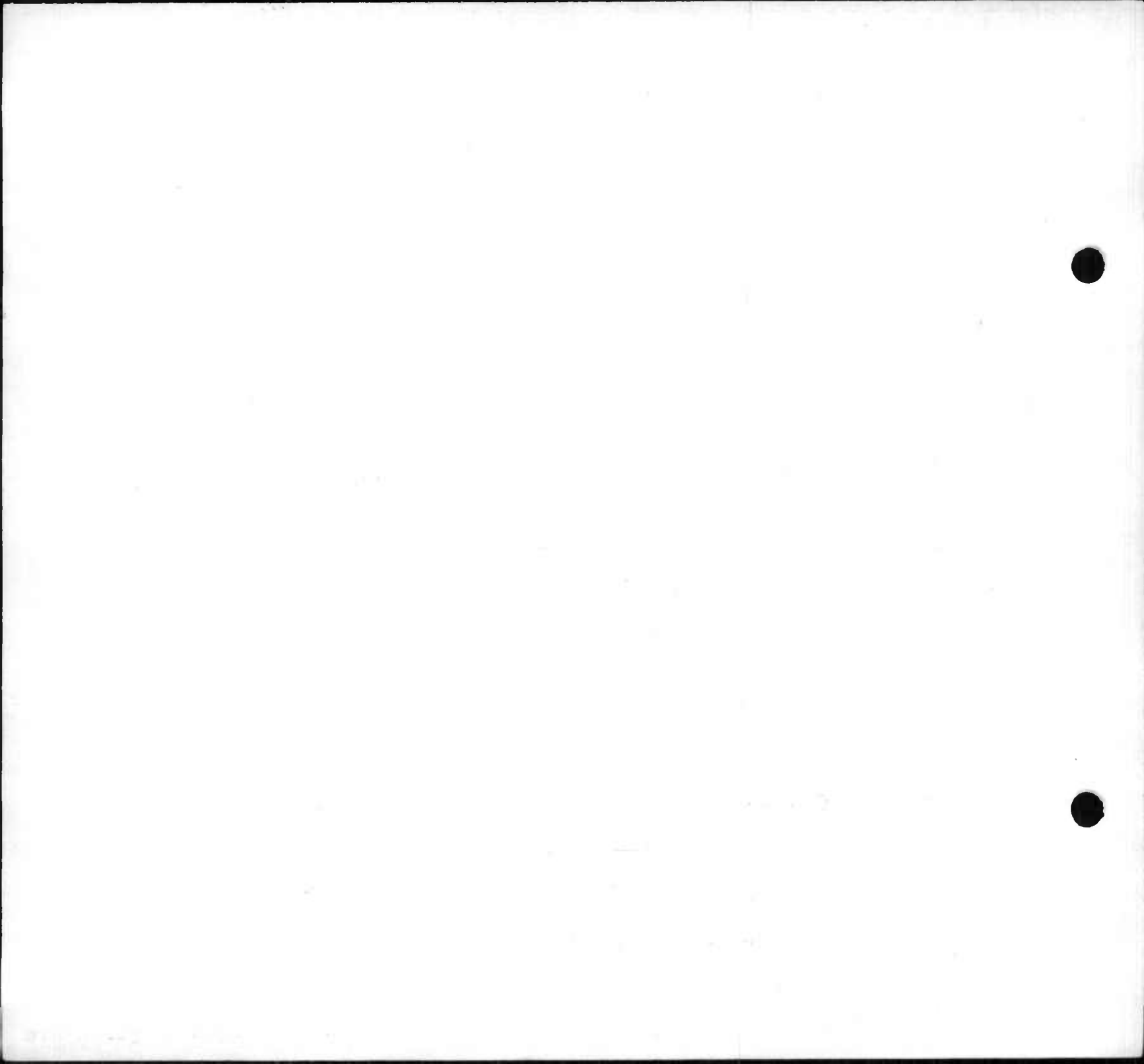
B-145 70 6899		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6899	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MARGARET E. BABYLON		2. DATE AND HOUR OF DEATH July 5/70 6 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived / institution; residence before admission) A. STATE B. COUNTY		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3446 KESWICK Rd.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb 10, 1893		9. AGE (In years lost birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALEX FRITZ	
14. MOTHER'S MAIDEN NAME MARGARET HOOPER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO -		16. SOCIAL SECURITY NO. 216-12-6815	
17. INFORMANT MRS. M. DOROTHY BABYLON BALTO. MD.		ADDRESS 3446 KESWICK RD.		18. CAUSE OF DEATH 410.9 I	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary occlusion 4 hours		ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis 10 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Jan 10 1958 to July 4 1970 , that (I) (we) last saw the deceased alive on July 3 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Leonard Wallenstein		23B. DATE SIGNED July 6/70		23C. PHYSICIAN'S NAME (Type) LEONARD WALLENSTEIN	
23D. ADDRESS 848 W 36th St		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 7/8/70	
24C. NAME OF CEMETERY or CREMATORY KRIDERS CEMETERY		24D. LOCATION (City, town, or county) (State) WESTMINSTER, MD.		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970	
25B. NAME OF REGISTRAR Robert E. Fisher, MD.		25C. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>70 6900</u>	
C-652 70 6900		CERTIFICATE OF DEATH	
BIRTH NO. <u>1</u>		1. NAME OF DECEASED (Type or Print) <u>JAMES CARMICHAEL</u>	
2. DATE AND HOUR OF DEATH <u>JULY 7, 1970 11:45 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALT. CITY</u>	
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>815 N. WOLFEST</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-21</u>
9. AGE (in years last birthday) <u>49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Carmichael</u>		14. MOTHER'S MAIDEN NAME <u>Sylvia Garrett</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Chart</u>		ADDRESS	
18. <u>453X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PULMONARY EMBOLUS</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>DEEP VEIN THROMBOSIS, LEGS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>JULY 1</u> 19 <u>70</u> to <u>JULY 7</u> 19 <u>70</u> that (1) (we) last saw the deceased alive on <u>JULY 7</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Steven E. Rubin MD</u>		23B. DATE SIGNED <u>July 7, 1970</u>	
23C. PHYSICIAN'S NAME (Type) <u>Steven E. Rubin, M.D.</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/14/70</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>MT Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		ADDRESS <u>1206 W North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-32570 6901		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6901	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lillian T. Watkins</i>		2. DATE AND HOUR OF DEATH <i>7/19/70 1255 P</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Granada Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4017 Liberty Hgts Ave</i>		A. STATE <i>MD.</i>	
				B. COUNTY <i>Baltimore</i>	
				C. CITY OR TOWN <i>Catonsville</i>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <i>315 Lambeth Rd 53-00</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-9-76</i>	9. AGE (in years last birthday) <i>93</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD</i>	
13. FATHER'S NAME <i>Daniel Tyler</i>		14. MOTHER'S MAIDEN NAME <i>Anna Cummings</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Granada Nursing Home 4017 Liberty Hgts</i>	
18. <i>4/10/9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>CORONARY THROMBOSIS</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) <i>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4/17/70</i> 19 to <i>7/19/70</i> 19 that (I) (we) last saw the deceased alive on <i>7/19/70</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Hollis Seunarine</i>		23B. DATE SIGNED <i>7/19/70</i>		23C. PHYSICIAN'S NAME (Type) <i>HOLLIS SEUNARINE</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/13/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Fork M. E. Church Cem</i>	
24D. LOCATION <i>Fork, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JUL 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Witzke, 1630 Edmondson Ave., 21228</i>		25D. ADDRESS		25E. ADDRESS	

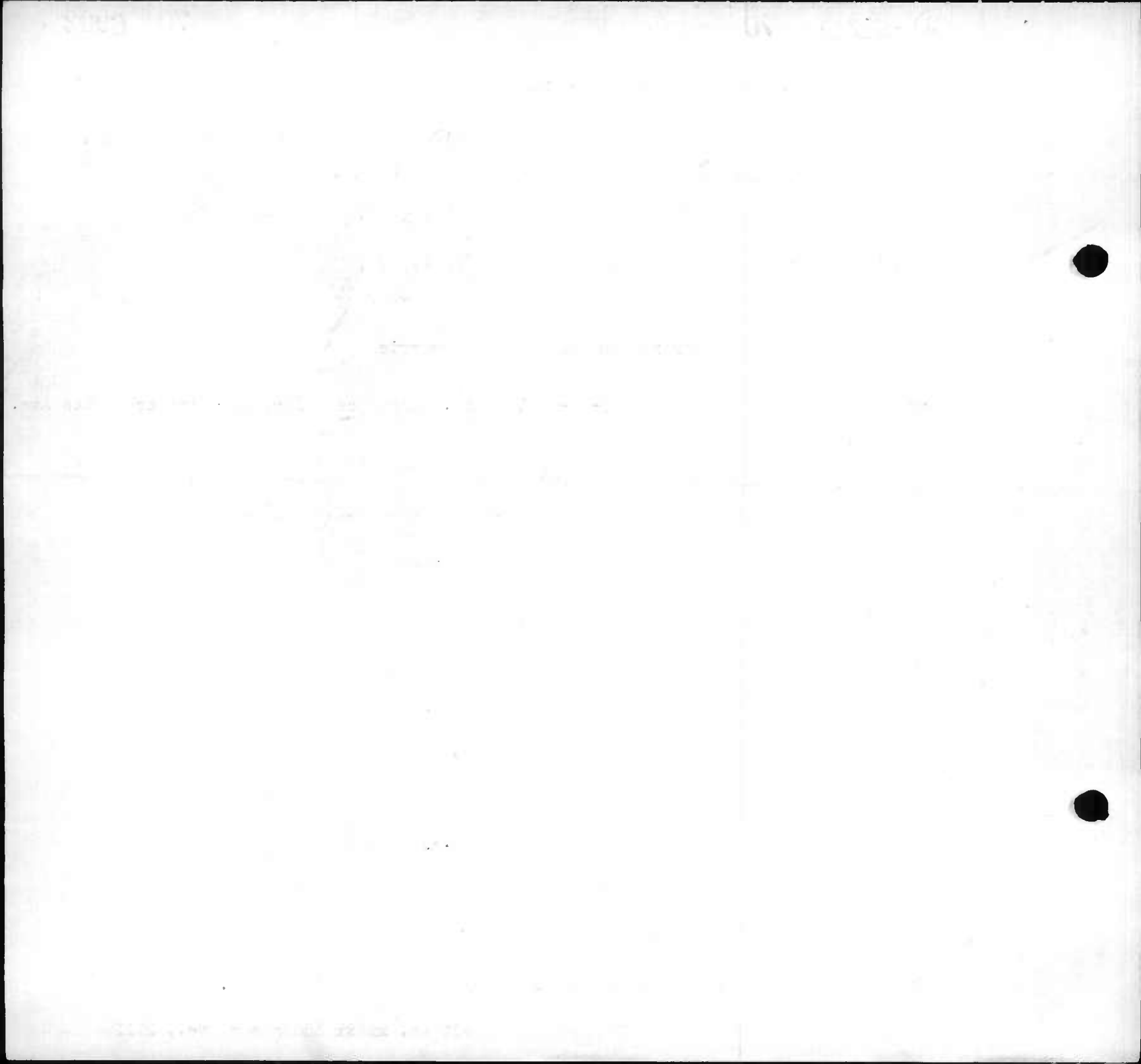
THIRTY

8 1/2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

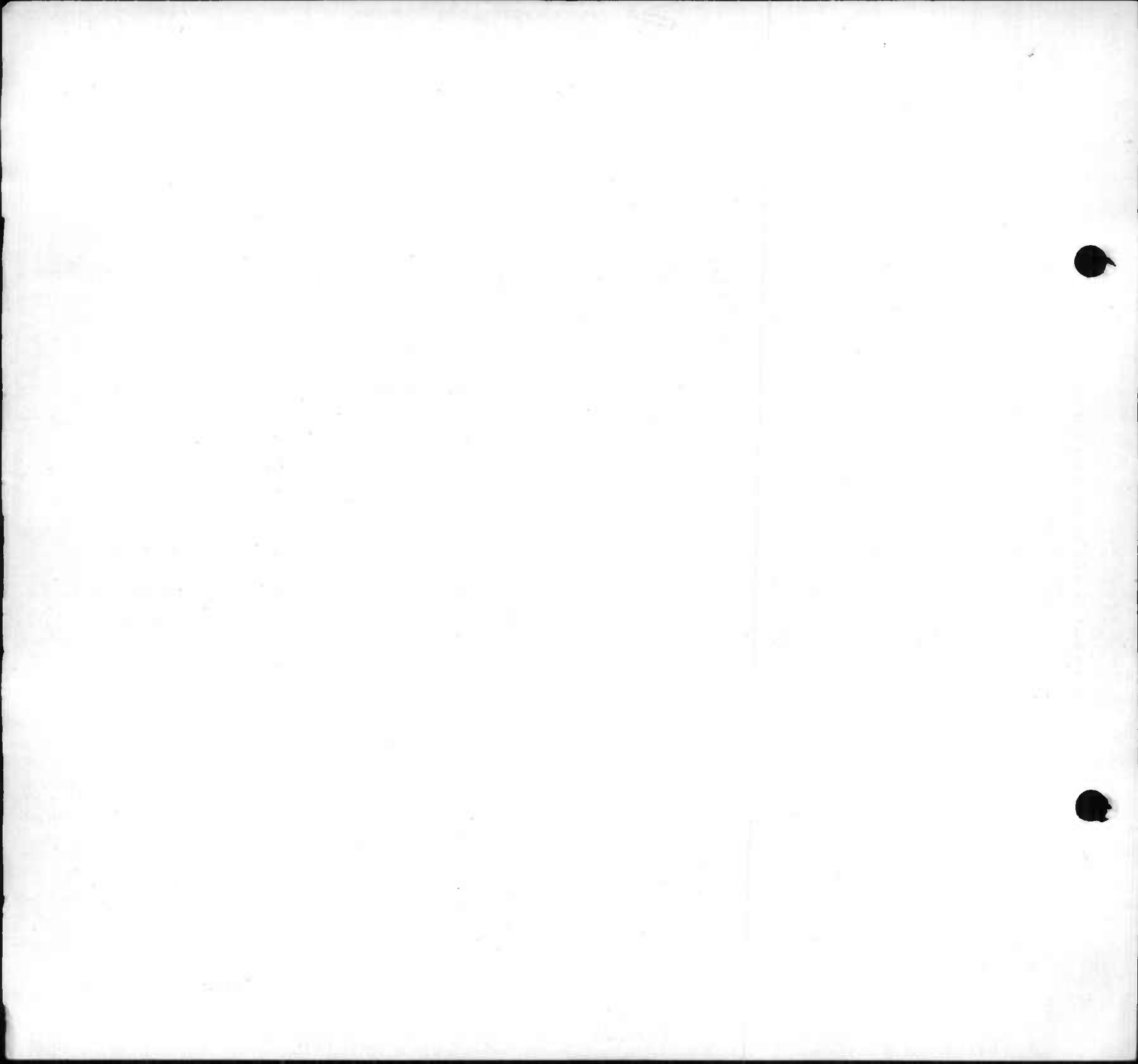
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
D-520 70 6902		70 6902		70 6902	
CERTIFICATE OF DEATH					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WILLIAM DUNNOCK		7/8/70 3:10 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE			
		B. COUNTY			
48 MARYLAND GEN HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		843 W. HOWING ST.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MALE	White	Single	7/7/07	62 yrs	None
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
				md	U.S.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
unknown Edward Dunnock			Carrie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		215-30-0997		Mrs. Constance Dolle, 4020 Massachusetts Ave.	
18. 5-99.01		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Cardiac Arrest			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(B) POSS. Septic Shock.			
ANTECEDENT CAUSES		(C) Urinary Tract Infection.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/3/1970 to 7/8/1970, that (I) (we) last saw the deceased alive on 7/8/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
M. AL - ISRAHIM				7/8/1970	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
M. AL - ISRAHIM				md. Gen. Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		7/10/70		Loudon Park Cemetery	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 10 1970		Jabari E. Jabari, R.S.		4101 Witzke, 21221 Edmondson Ave., 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

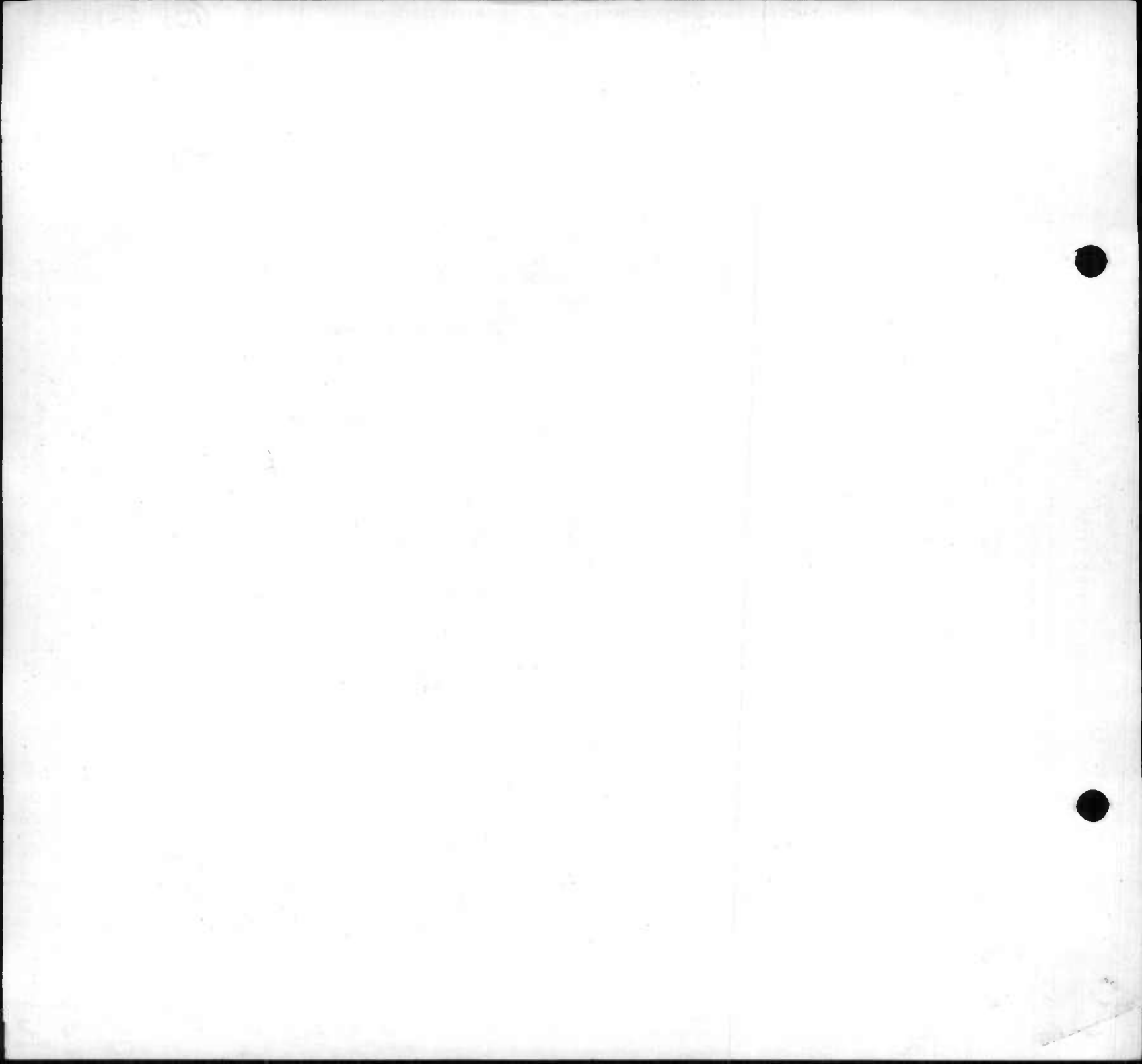
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6903</u>	
J-250 70 6903		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HATTIE Virginia (BOOZE) JACKSON		7-5-70 11:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 633 North Fulton Avenue Baltimore, Maryland		A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 633 North Fulton Avenue			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-97	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Joseph B. Booze		14. MOTHER'S MAIDEN NAME Georgia Hill		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-03-7014		17. INFORMANT ADDRESS Miss Gertrude Bowers 633 N. Fulton Ave. Mr. Charles Bowers 521 Radnor Ave. 21212	
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ASHD & congestive heart failure & probably acute 1-2 weeks CARDIAC ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>7/3</u> <u>1970</u> to <u>7/5</u> <u>1970</u> , that (I) (we) last saw the deceased alive on <u>7/3</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Elijah B. Saunders</u> DEGREE				23B. DATE SIGNED <u>7/7/70</u>	
23C. PHYSICIAN'S NAME (Type) Dr. Elijah B. Saunders		23D. ADDRESS 2300 Garrison Blvd.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 7-9-1970		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR 1735 Harford Avenue Marshall W. Jones, Jr.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6904	
70 6904				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Batch, Mary		2. DATE AND HOUR OF DEATH 2:40 AM 7-4-70	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 3517 White Chapel Rd. B. COUNTY 151511		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital of Md.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		5. SEX Female		6. RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-90		9. AGE (In years last birthday) 80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.S.A	
13. FATHER'S NAME Mrs. Gordon		14. MOTHER'S MAIDEN NAME Anna Perkins		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Ruth Batchu 3517 White Chapel	
18. 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction Circulatory arrest. (B) Arteriosclerosis, vascular thrombosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-30-70 7-4-70	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Parkinson disease.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11:10 AM 6-30 1970 to 2:40 AM 7-4-1970 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 19 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 7-4-70	
23C. PHYSICIAN'S NAME (Type) Nassir SAGHAFI, M.D.				23D. ADDRESS Lutheran Hosp. of Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-70		24C. NAME OF CEMETERY or CREMATORY Jefferson Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECD BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR J. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR J. S. Waters		25D. ADDRESS 344 [Address]		25E. CITY, STATE, ZIP Baltimore, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 70 6905

BIRTH NO. 70 6905

1. NAME OF DECEASED

(Type or Print)

Herbert Keys

2. DATE AND HOUR OF DEATH

7/7/70

5:15 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hosp.
Merdy Hospital, Inc.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

313 East St

5. SEX

M

6. RACE

N

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

3/15/08

9. AGE (in years last birthday)

62

10. Under 1 Yr.

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Thomas Keys

14. MOTHER'S MAIDEN NAME

Nonnie Times

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

218-01-9768

17. INFORMANT

Hospital Record

ADDRESS

18.

436.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Vascular accident

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Left Cerebralgia

(C)

Pneumonia, left lung

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 21 1970 to July 7 1970 that (I) (we) last saw the deceased alive on July 7 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Boo Keun Kim, M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

July 7, 1970

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

Mercy Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

Burial 7-11-70

24C. NAME of CEMETERY or CREMATORY

St. Calvary Cem. A. A. Co.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

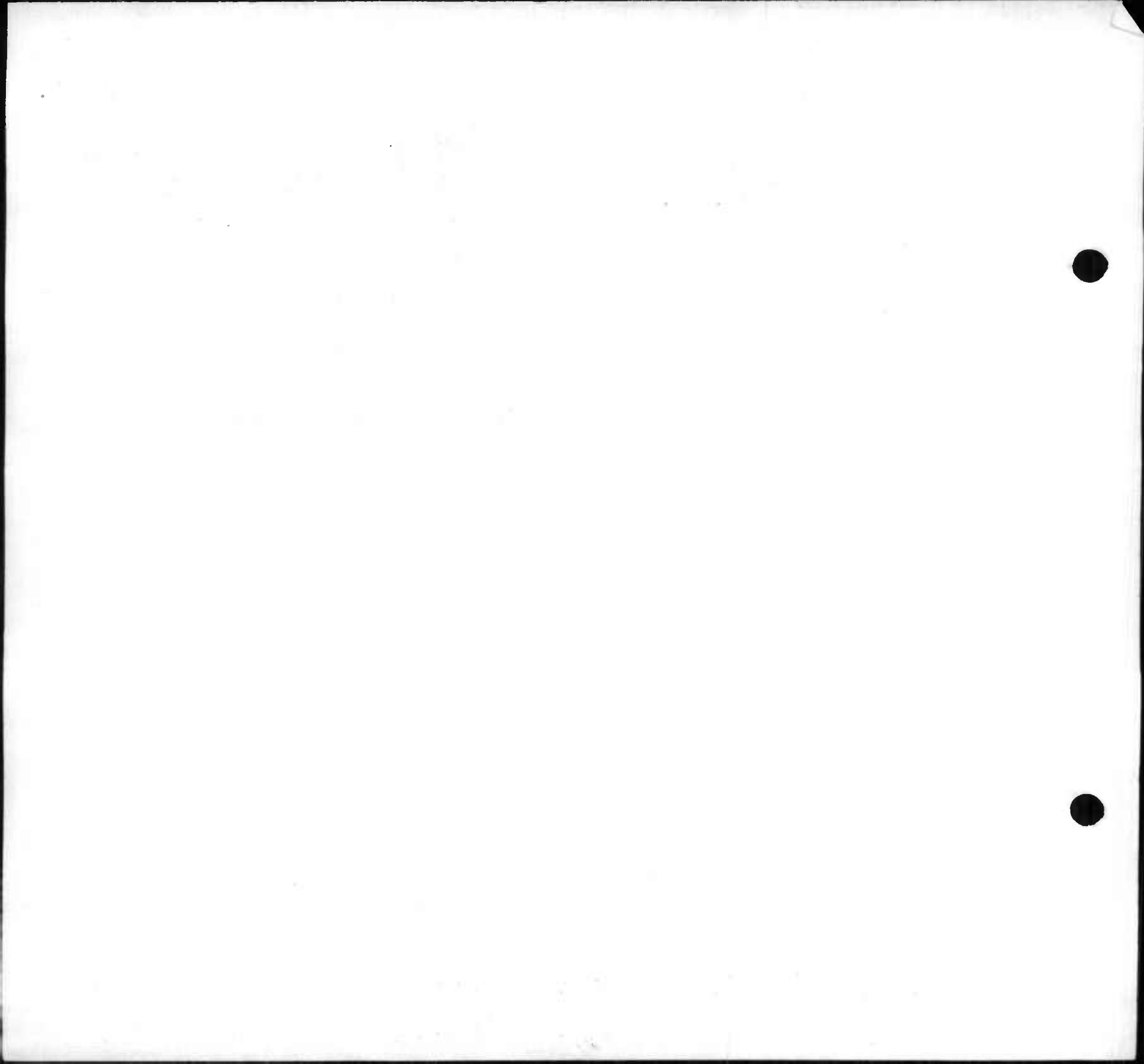
JUL 10 1970

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Raymond Sandusky, Jr.



70

6906

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70

6906

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HENRY MOTLEY

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

4 June 25

1970

4:55 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION, ONE STREET
ADDRESS OR LOCATION

OR INSTITUTION

Provident Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

6

25

1970

4:55 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

Md.

B. COUNTY

1403

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4-19-07

10. AGE (In years
lost birthday)

63

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2029 Madison Ave.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

James Motley

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Hallie Crandall

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Thelma Southall

Va

19.

412.4

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Chronic obstructive pulmonary disease

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalek, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

6-26-70

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

7-1-70

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Em.

24D. LOCATION (City, town, or county)

A.A. Co.

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 10 1970

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Rayner Sanders

ADDRESS

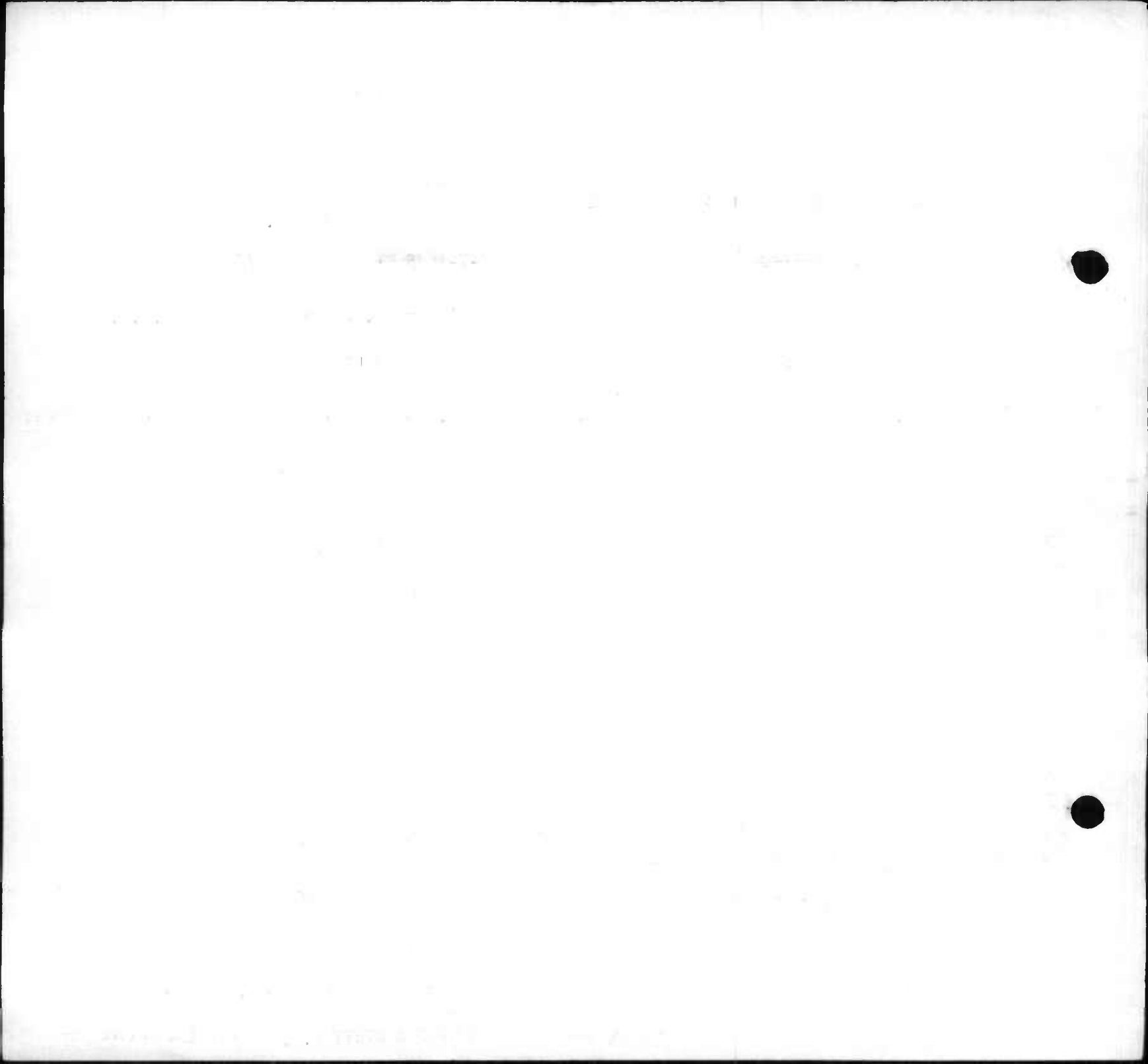
2176 Preston St

Letter from M.E.'s office 7-16-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6907	
BIRTH NO. 70 6907				CERTIFICATE OF DEATH	
1. NAME OF DECEASED Type or Print <u>Julia Evans</u>			2. DATE AND HOUR OF DEATH <u>7/8/70</u> <u>1:45</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE JOHNS HOPKINS HOSPITAL</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2037</u>		
5. SEX <u>FEMALE</u>			6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Halifax Co., Virginia</u>	
13. FATHER'S NAME <u>MOSES POUND</u>			14. MOTHER'S MAIDEN NAME <u>EMALIE BOWMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>229-12-9651B</u>		17. INFORMANT ADDRESS <u>Mrs. Juanita Britton 408 Allendale Street</u>	
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1. This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(A) IMMEDIATE CAUSE <u>Cardiac & Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Coronary Vascular Accident</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1'55"</u> <u>24hr</u> <u>20hr</u>
19A. DATE OF OPERATION <u>3/7/2/70</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pulmonary & duodenal obstruction</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 6</u> 19 <u>70</u> to <u>July 8</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>3:30 pm 7/8</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William J. Anderson M.D.</u>			23B. DATE SIGNED <u>7/8/70</u>		23C. PHYSICIAN'S NAME (Type) <u>William J. Anderson</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7-11-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>
24D. LOCATION <u>Baltimore, Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR, ADDRESS <u>MORTON & DYETT F.H. 1701 LAURENS ST.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-463 1

70 6908

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

70 6908

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Williams, Lillie

2. DATE AND HOUR OF DEATH

July 9 10:20 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Mary's Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Balt.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2503 Linden Ave

5. SEX

F

6. RACE

AA

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

8/1/92

9. AGE (in years last birthday)

77

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md. Balt.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Boston

14. MOTHER'S MAIDEN NAME

Ellie Freeman

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-01-0673-A

17. INFORMANT

Mrs. Zona Sheffey 2503 Linden Ave

ADDRESS

18. CAUSE OF DEATH

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/9/70 to 7/9/70 that (I) (we) last saw the deceased alive on 7/9/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

John E. Taylor

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

7/9/70

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/13/70

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

24D. LOCATION

Balt.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 10 1970

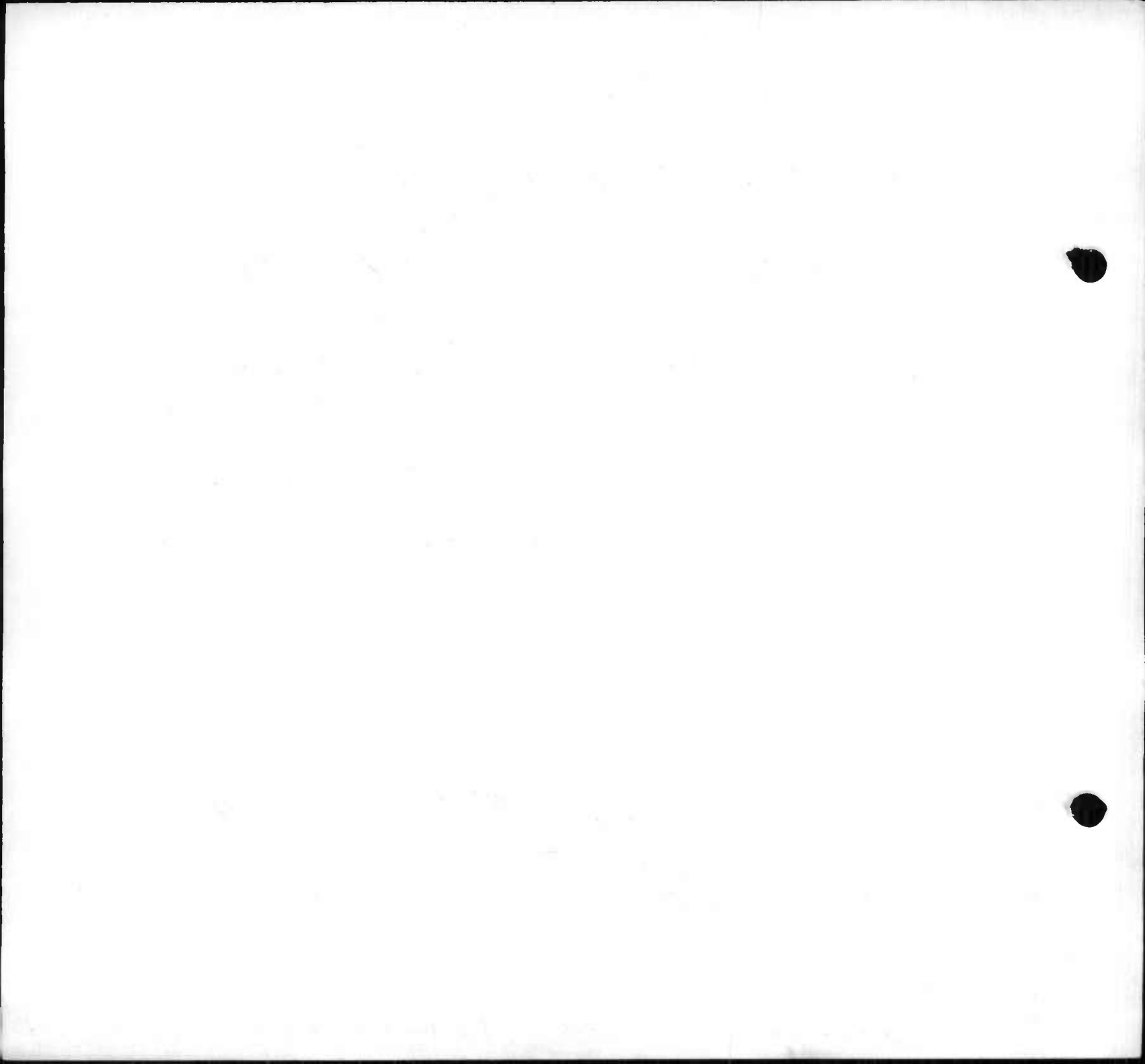
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

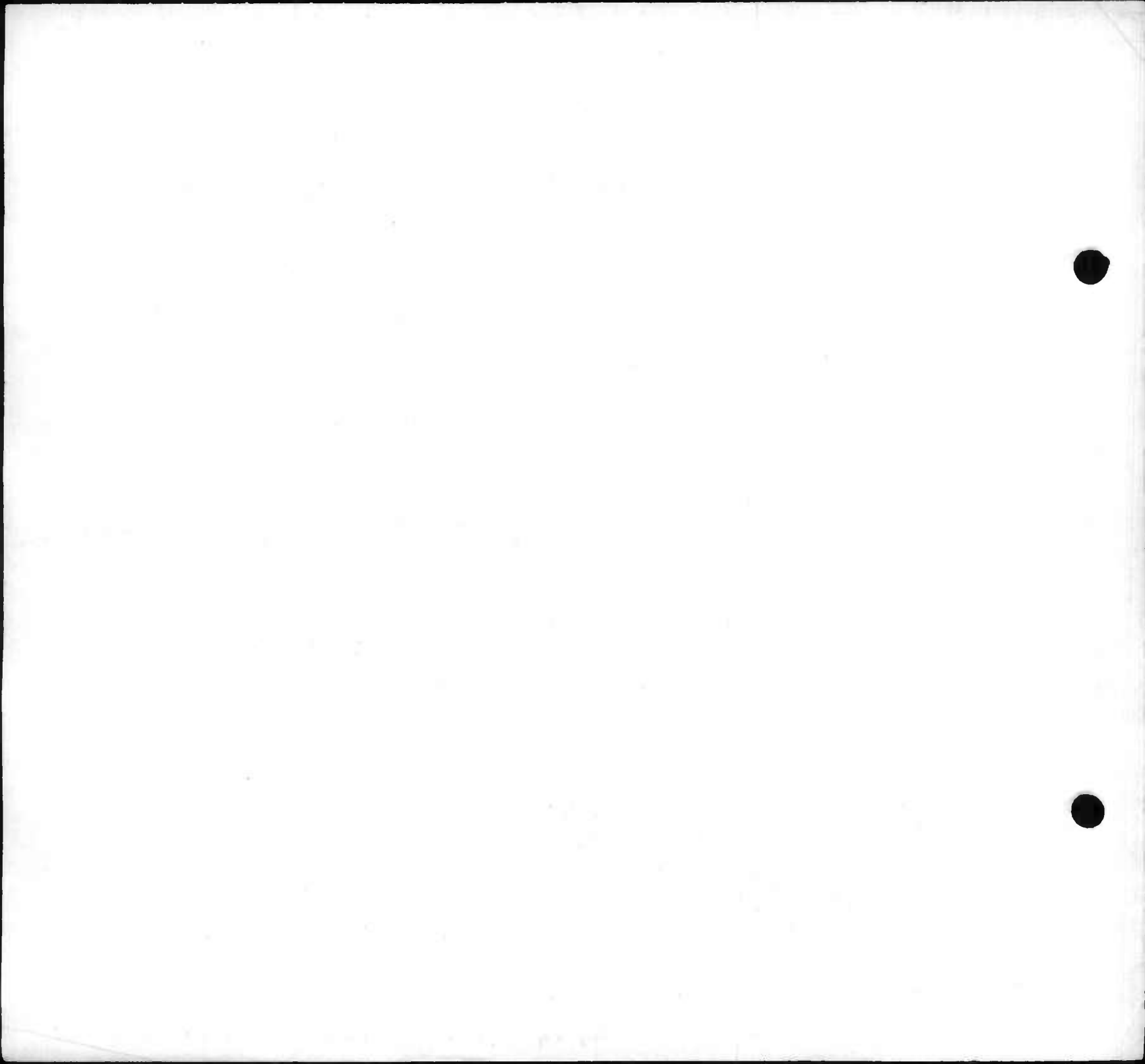
Moeton & Dyett F. H. 1701 Laurens St.

ADDRESS



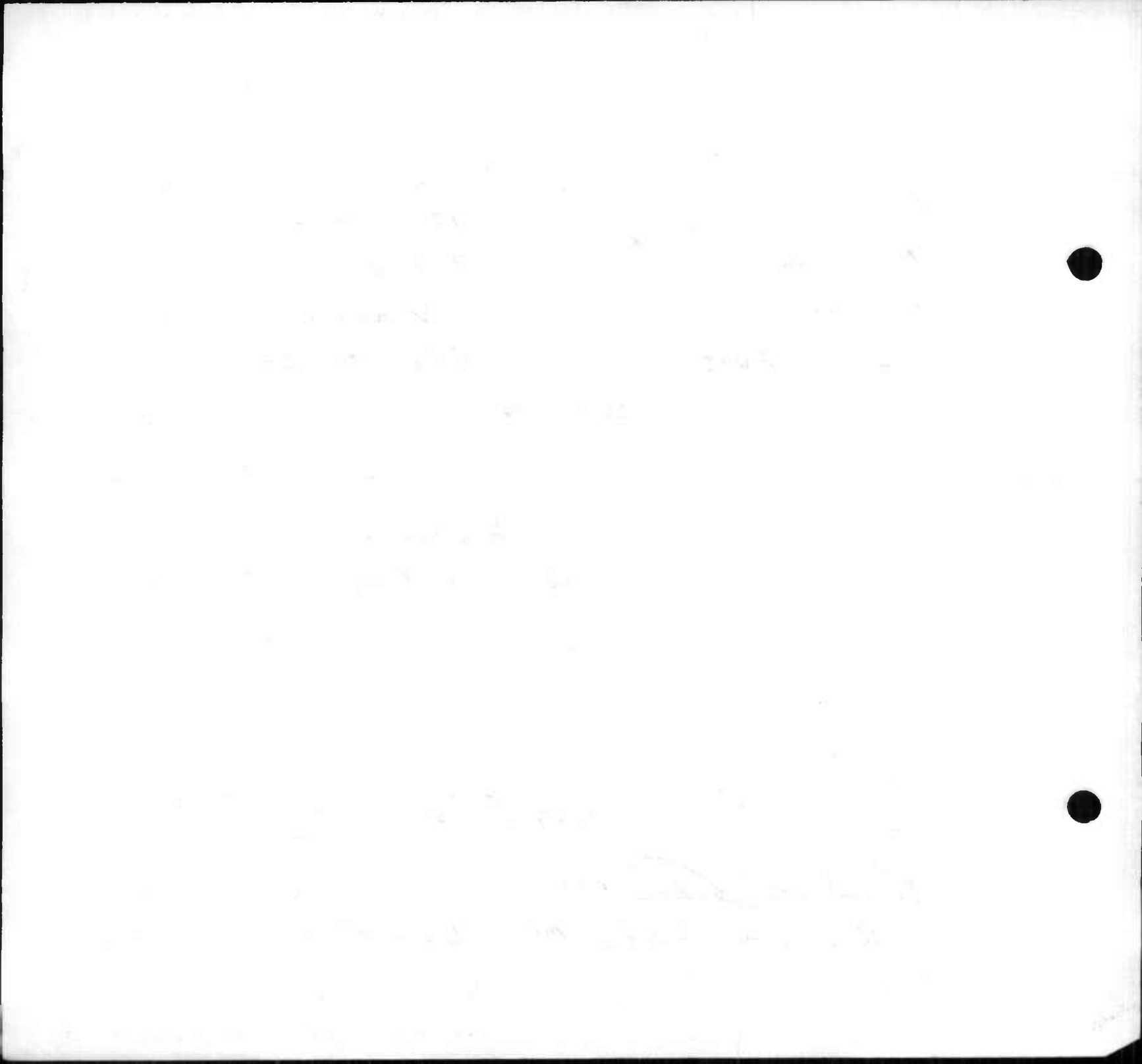
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 6909		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6909	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Sandra Johnson (Brown)</u>		2. DATE AND HOUR OF DEATH <u>7/8/70</u> <u>11:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Johns Hopkins Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>810 Abbott Ct.</u>	
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/8/51</u>	9. AGE (in years last birthday) <u>18</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Sollieth, Illinois</u>	
13. FATHER'S NAME <u>Robert Dudley</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Reed</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>218-58-3011</u>		17. INFORMANT <u>Mrs. Sadie Dudley</u> ADDRESS <u>1215 Wildwood Parkway</u>	
18. <u>430.9</u> I CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Intracranial Hemorrhage</u>			
		(B) <u>Bifurcation Aneurysm @ Carotid Artery - 1 month</u> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>? Normal Delivery IUP</u>		<u>1 month (5 weeks)</u>	
19A. DATE OF OPERATION <u>6/12/70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carotid Artery Aneurysm</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/2</u> 19 <u>70</u> to <u>7/8</u> 19 <u>70</u> that (I) (we) lost saw the deceased alive on <u>7/8</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>DM Haines</u>		23B. DATE SIGNED <u>7/8/70</u>		23C. PHYSICIAN'S NAME (Type) <u>DM Haines</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-13-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Western Star Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Morton & Dgett F. H.</u>	
		24D. LOCATION (City, town, or county) (State) <u>Catonsville, Maryland</u>		25D. ADDRESS <u>1701 Laurens St.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

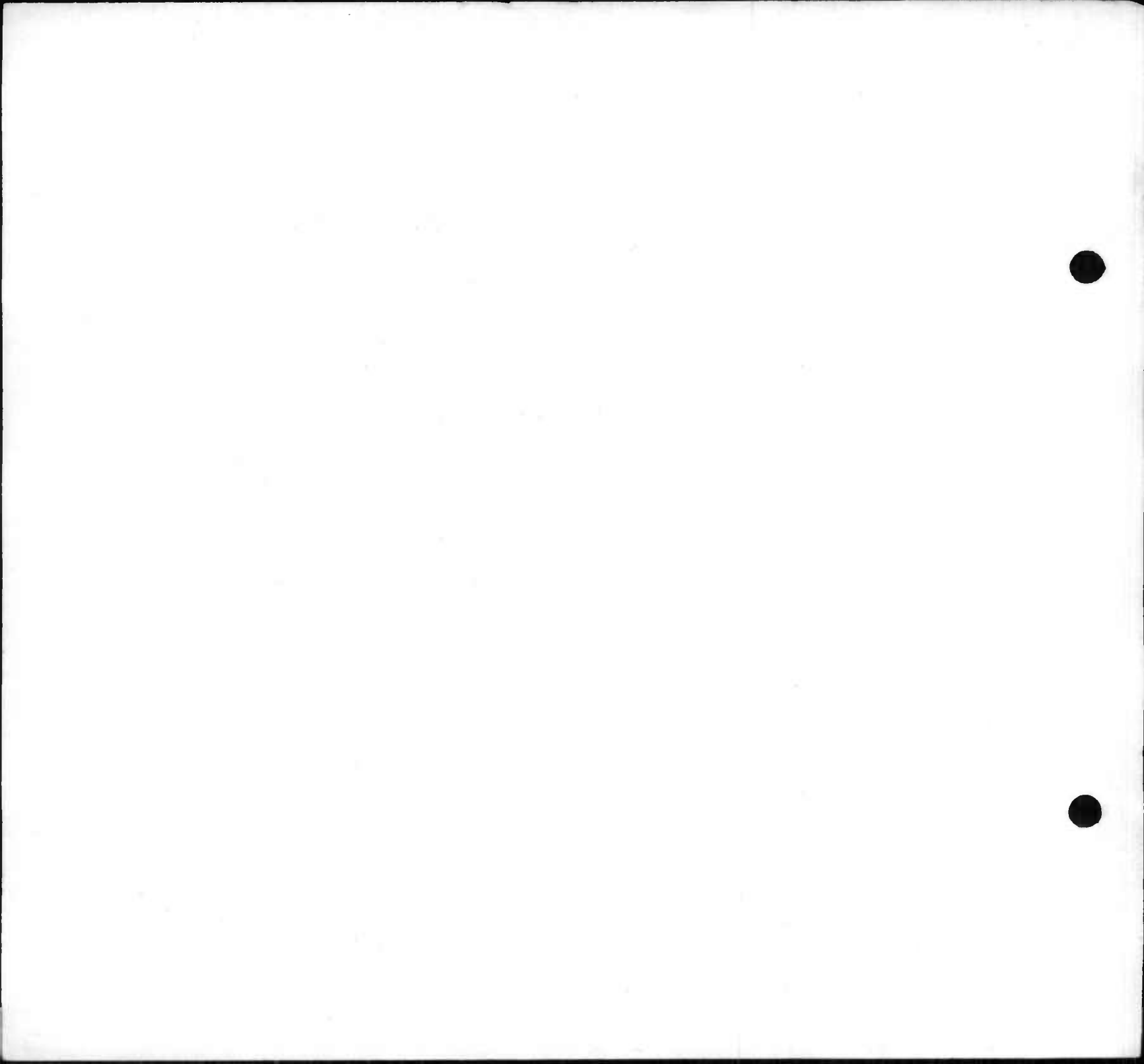
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		70 6910		70 6910	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>JAMES I Hunt</u>				2. DATE AND HOUR OF DEATH <u>7/9/70</u> <u>11:15 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2739</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1215 Winstan Ave</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/20</u>	9. AGE (In years last birthday) <u>50</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Love Hunt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Crahan</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>10/9/42 - 1/2/46</u>		16. SOCIAL SECURITY NO. <u>22320 5774</u>		17. INFORMANT <u>Mrs. Annie Hunt</u>		ADDRESS <u>1215 Winstan Ave</u>	
18. <u>354 X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>hypotensive episode</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Guillain Barre Syndrome</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 1/2 hour</u> <u>3 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Upper Respiratory Infection</u>						<u>4 weeks</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6/20/70</u> 19 <u>70</u> to <u>7/9/70</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>7/9/70</u> 19 <u>70</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ronald W. Geckler MD</u>				23B. DATE SIGNED <u>7/9/70</u>		23C. ADDRESS <u>Union Memorial Hospital Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/12/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Springfield Mt. Ch. Cem. Mechanicsville, Virginia</u>		24D. LOCATION (City, town, or county) (State) <u>Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton E. Dyett F.H. 1701 Laurens St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

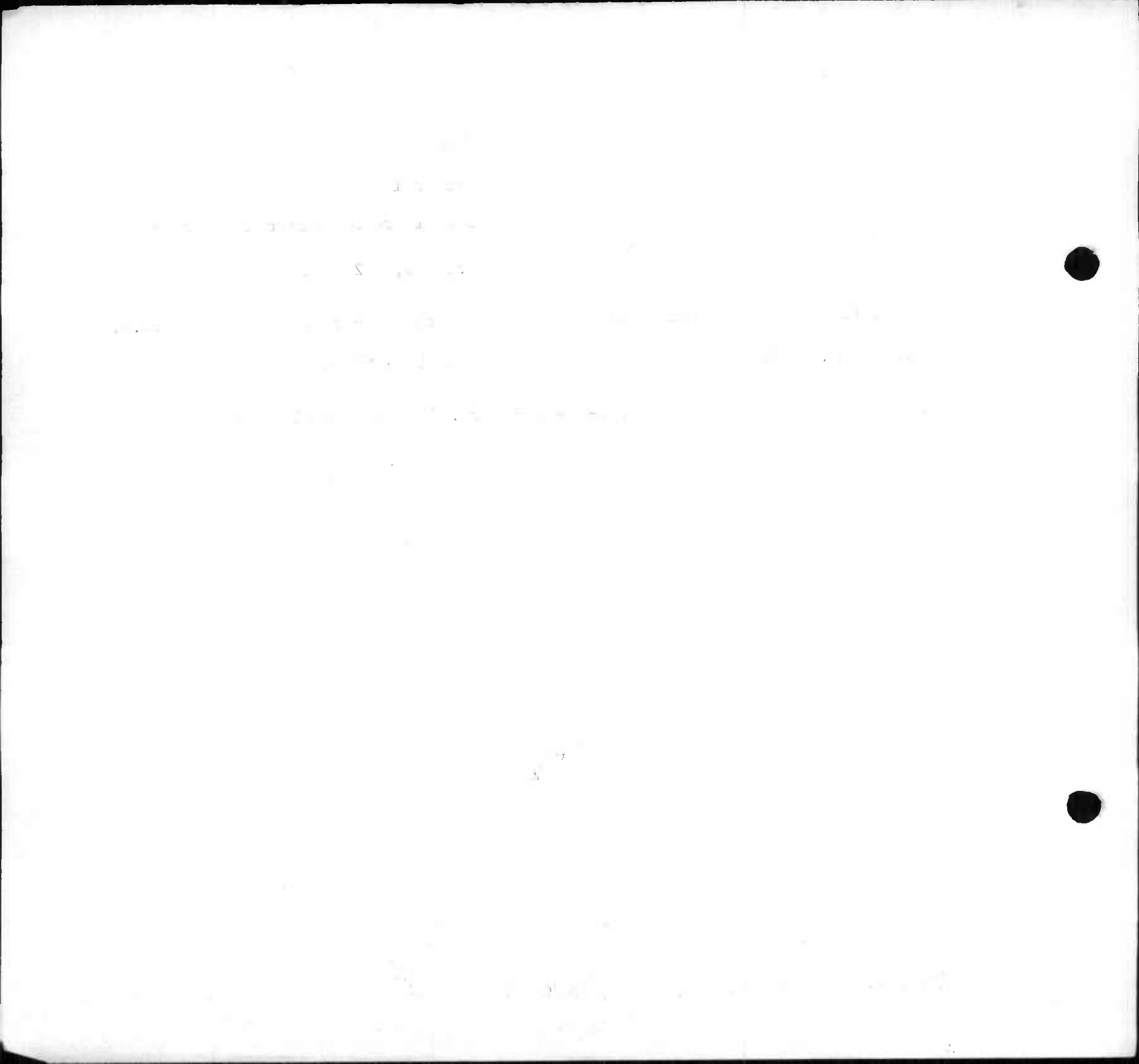
70 6911		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		70 6911	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>DOROTHY R. SHEPHERD (ROSS)</i>		2. DATE AND HOUR OF DEATH <i>7/8/70</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Balto.</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>31 CITY HOSPITAL</i>		C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <i>44A FENWAY SOUTH</i>					
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/5/1911</i>	9. AGE (In years lost birthday) <i>58</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CLERK</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>DEPT. STORE</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>JESSE BARNES</i>		14. MOTHER'S MAIDEN NAME <i>DOROTHY B. MILLS</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219225356</i>		17. INFORMANT <i>W. John J. Shepherd - 44A Fenway South</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac arrest</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>G. I. Bleeding</i> (C) <i>Anti Coagulant Therapy</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>July 3</i> 19 <i>70</i> to <i>July 8</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on <i>July 3</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Charles C MacMinn MD</i>		23B. DATE SIGNED <i>July 10, 1970</i>		23C. PHYSICIAN'S NAME (Type) <i>CHARLES C MACMINN</i>	
23D. ADDRESS <i>2900 E BALTIMORE ST</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7/11/70</i>	
24C. NAME OF CEMETERY or CREMATORY <i>oak lawn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO., MD.</i>		25A. DATE RECD BY HEALTH DEPT. <i>JUL 10 1970</i>	
25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>		25C. FUNERAL DIRECTOR <i>Garth Miller - 2334 Jefferson St.</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH			
BIRTH NO. 70 6912		REG. NO. 70 6912	
1. NAME OF DECEASED (Type or Print) <i>Arthur E. Irwin</i>		2. DATE AND HOUR OF DEATH <i>7-6-70 1:05 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>37 Mercy Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Lutherville</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <i>519 Riderwood Lutherville Drive</i>	
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 15, 1912</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Automobile</i>	9. AGE (In years last birthday) <i>58</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas J. Irwin</i>		14. MOTHER'S MAIDEN NAME <i>Fannie Schelhouse</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>705-03-9566</i>	
17. INFORMANT <i>Mrs. Catherine Irwin</i>		ADDRESS <i>Same as # 4 E</i>	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
(A) IMMEDIATE CAUSE <i>Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Diabetes Mellitus -</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/6/1970</i> to <i>7/6/1970</i> that (I) (we) last saw the deceased alive on <i>7/6/1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>K. Irwin</i>		23B. DATE SIGNED <i>7/6/70</i>	
23C. PHYSICIAN'S NAME (Type) <i>KYI KYI LWIN</i>		23D. ADDRESS <i>Mercy Hospital</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7-9-1970</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Dulaney Valley Memorial</i>		24D. LOCATION (City, town, or county) (State) <i>Cockeysville, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i>	
25C. FUNERAL DIRECTOR <i>Wm. Cook - Brookstown</i>		ADDRESS <i>Brookstown Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 6913		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6913	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELIZABETH T. MC CAULEY		2. DATE AND HOUR OF DEATH July 7, 1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home 115 East Melrose Avenue 21212		C. CITY OR TOWN Baltimore		E. STREET AND NUMBER Guilford North Ave.	
5. SEX female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1884	9. AGE (In years last birthday) 85 Yrs.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect'y.		10B. KIND OF BUSINESS OR INDUSTRY Bank		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William A. Trader		14. MOTHER'S MAIDEN NAME Ida T. Williams	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service)		16. SOCIAL SECURITY NO. 216-07-3638		17. INFORMANT Mr. William H. Gaskill, Jr.	
				ADDRESS 1512 W. Joppa Road Baltimore, Md. 21204	
18. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Senile Mentality		6 yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-19 19 64 to 7-7 19 70 , that (I) (we) last saw the deceased alive on 7-5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE W.P. Benson, Jr. M.D.				23B. DATE SIGNED July 9, 1970	
23C. PHYSICIAN'S NAME (Type) William P. Benson, M. D.				23D. ADDRESS 3502 N. Calvert Street, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10, 1970		24C. NAME OF CEMETERY or CREMATORY Galena Cemetery	
24D. LOCATION (City, town, or county) (State) Galena, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Wm. Cook-Brooks		25D. ADDRESS Towson, Maryland		25E. ADDRESS 1050 York Road	

820 Guilford Ave.
(Poik Directory)

70 6914 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6914

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARQUEST OLIVER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour July 9, 1970 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour July 9, 1970 1:45:A M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 802		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Aug 4, 1932		10. AGE (In years last birthday) 37	
11. BIRTH PLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
15. MOTHER'S MAIDEN NAME MARIE JENNINGS		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 224-34-2027		18. INFORMANT ADDRESS MARY OLIVER 2123 Chestnut Ave	
19. CAUSE OF DEATH E965X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II 20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes		(A) IMMEDIATE CAUSE Gunshot wound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? In front of 1405 Montford Avenue 833		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-9-70 about 1:40 A.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED July 9, 1970 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/70	
24C. NAME OF CEMETERY or CREMATORY Oliver Cem.		24D. LOCATION (City, town, or county) (State) Chesapeake, VA	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Joseph E. Locks		25D. ADDRESS 1304 N. Central	

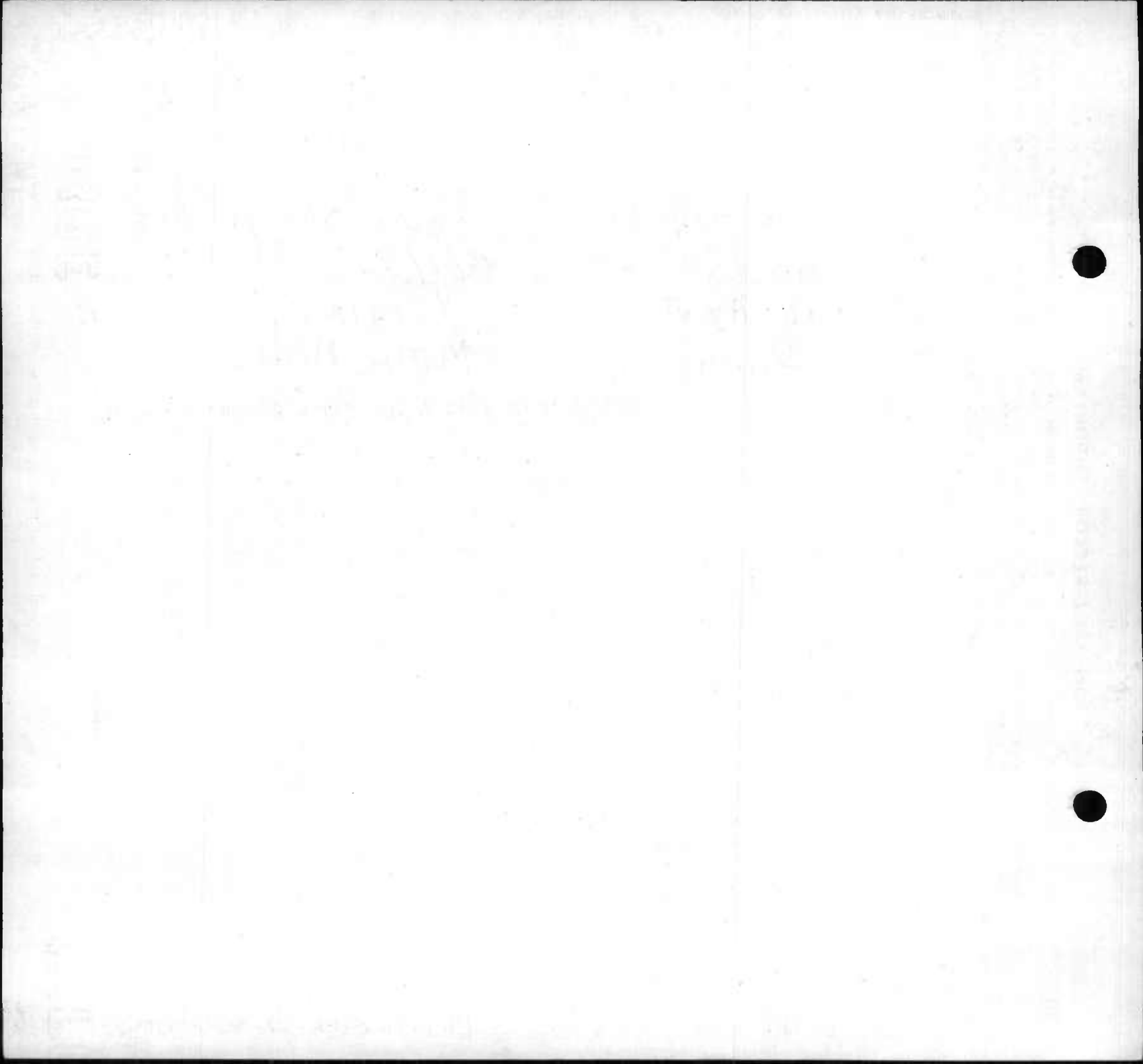
5E

Cliftwood Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

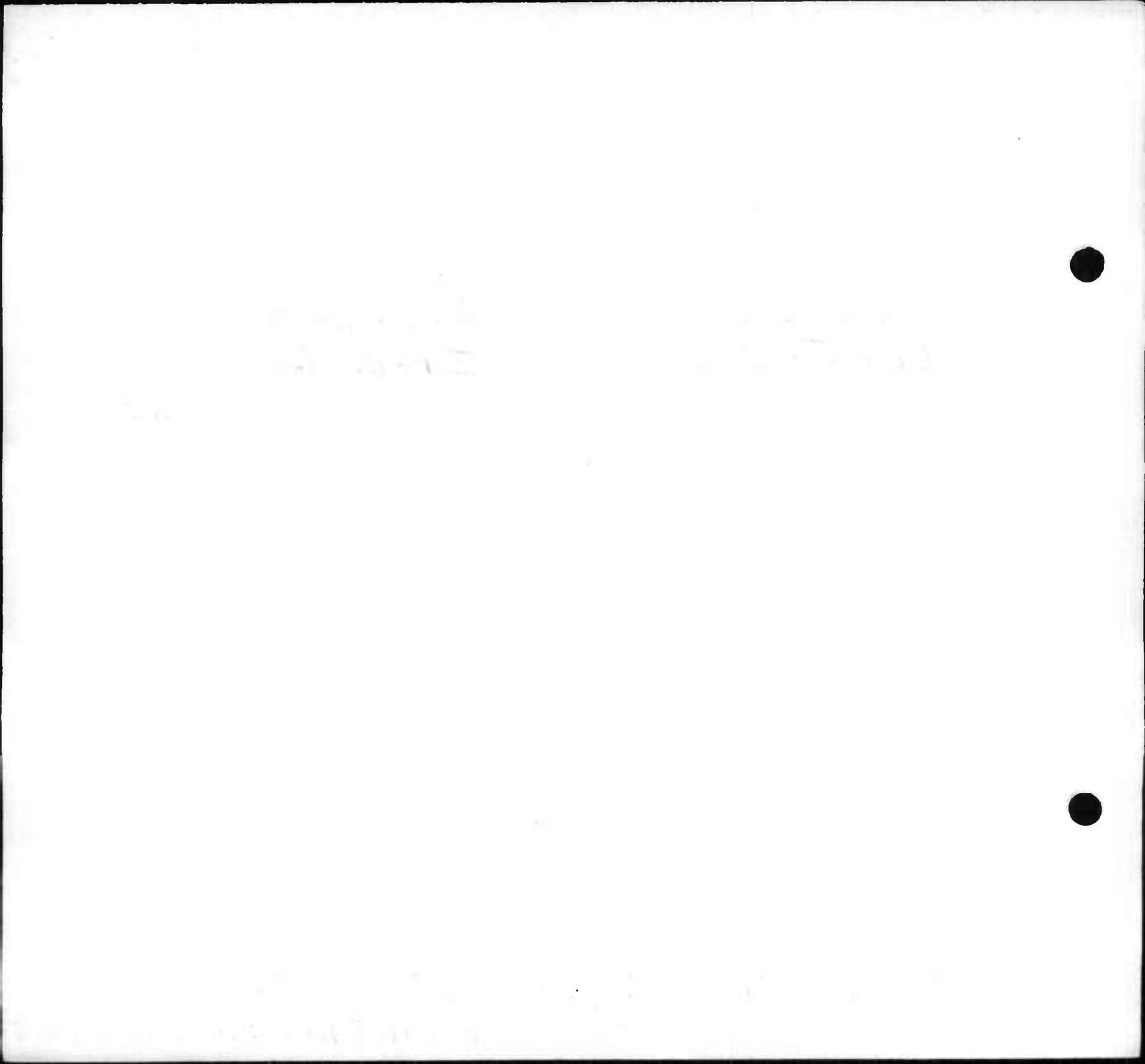
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6915
70 6915		CERTIFICATE OF DEATH		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Bessie Matthews		7/6/70 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		A. STATE Maryland B. COUNTY 1548		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
S. SEX Female		E. STREET AND NUMBER 2221 Roslyn Ave		
6. RACE Colored		8. DATE OF BIRTH 10/11/95		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 74		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		
Retired (No Agent)		Virginia		
13. FATHER'S NAME James Duphy		14. MOTHER'S MAIDEN NAME Mattie Matthews		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT ADDRESS		
No		Mrs Willie Mae Oakman - 2221 Roslyn Ave		
16. SOCIAL SECURITY NO. 212-14-1840		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		
436.92 I 250.9		Cerebrovascular Accident		
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Generalized Atherosclerosis		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
		Diabetes mellitus		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0				No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from approximately 10 years to June 19 70 , that (I) (we) last saw the deceased alive on June 16 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Faith B Davis MD				23B. DATE SIGNED 7/8/70
23C. PHYSICIAN'S NAME (Type) FAITH B. DAVIS MD				23D. ADDRESS Baltimore City Hospitals
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY
Burial		July 11, 1970		Arbutus Mem. Park
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR ADDRESS M. HOWE ELICKSON - 129 N. Caroline St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

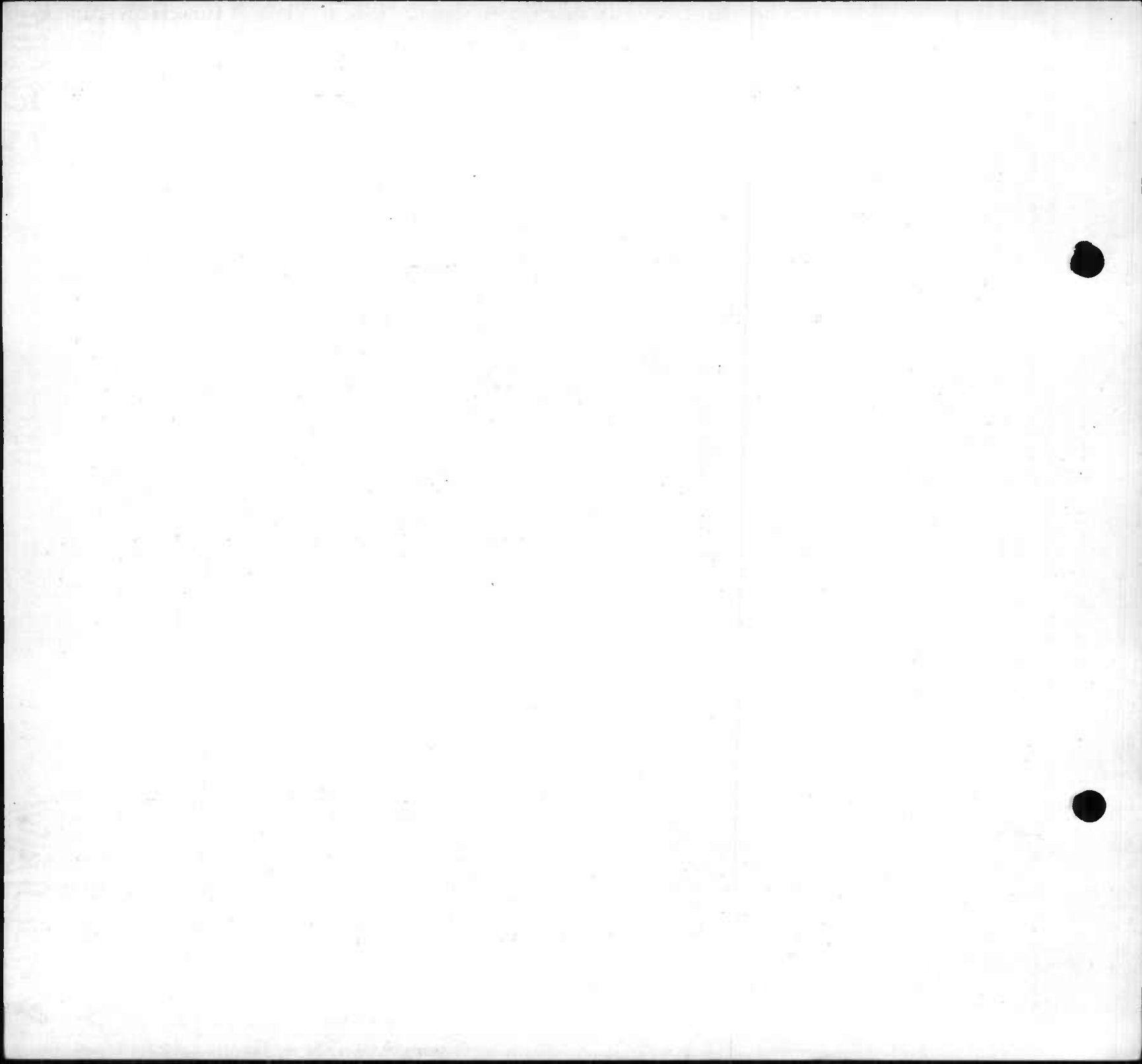
BALTIMORE CITY HEALTH DEPARTMENT		70 6916		CERTIFICATE OF DEATH		REG. NO. 70 6916	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) THELMA N. WADE			
2. DATE AND HOUR OF DEATH 7-8-70 5:15 P.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1503			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTO. GENERAL HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 2-9-09		9. AGE (In years last birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W. Virginia	
13. FATHER'S NAME Eli Jordan				14. MOTHER'S MAIDEN NAME Irene Gray			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT MELVIN WADE - SAME	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ARTERIO SCLEROTIC CARDIO VASCULAR DUE TO, OR AS A CONSEQUENCE OF: DISEASE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7-8-70 to 7-8-70 and that (I) (we) last saw the deceased alive on 7-8-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Lilia C. Baldonado M.D.				23B. DATE SIGNED 7-8-70		23C. PHYSICIAN'S NAME (Type) LILIA C. BALDONADO M.D.	
23D. ADDRESS 586H - 3001 S. HANOVER ST. BALTO. MD.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/70		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Farber M.D.		25C. FUNERAL DIRECTOR Zorah T. Elickson		ADDRESS 139 N. Caroline St.	



FUNERAL DIRECTOR: IMPORTANT

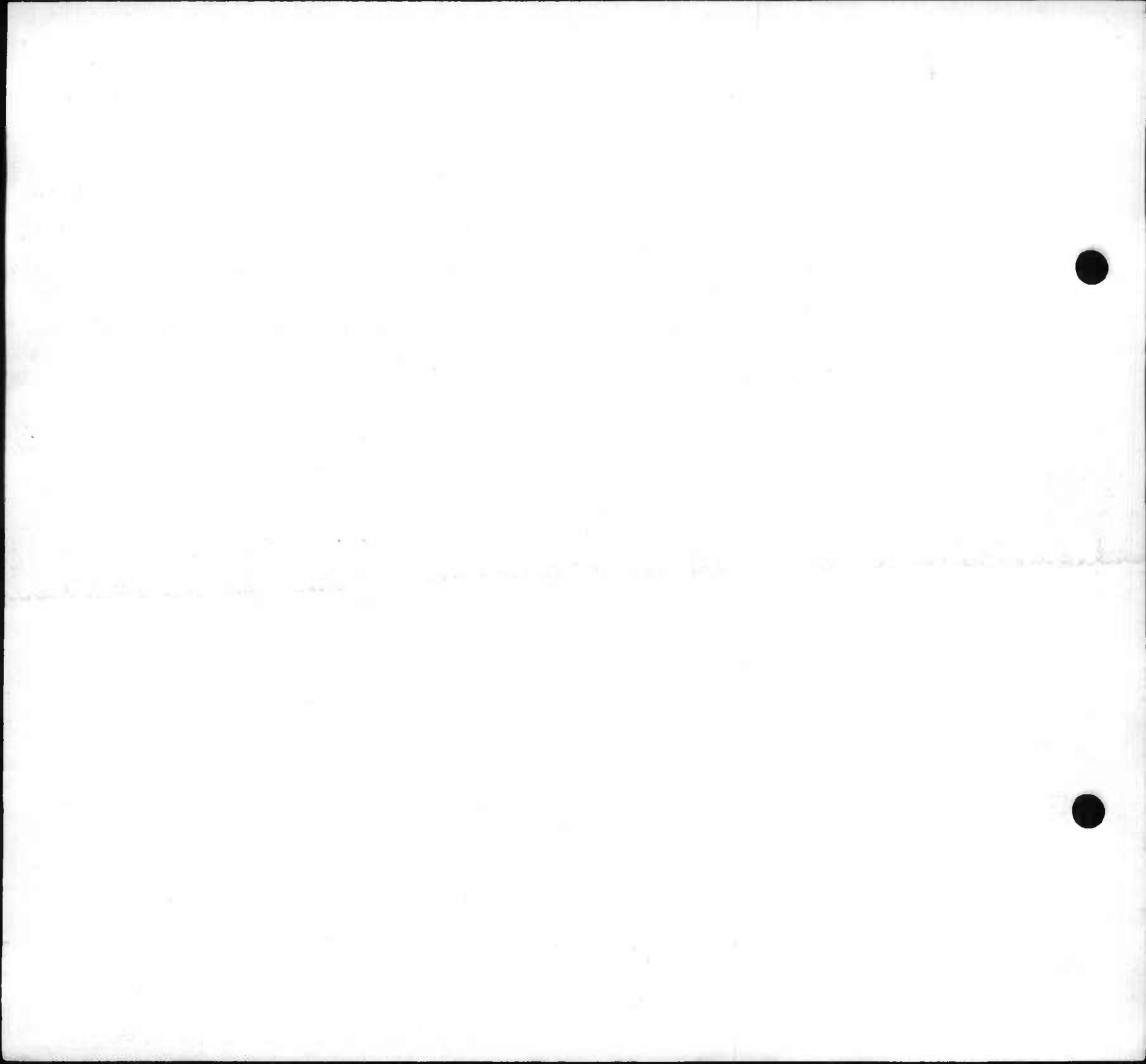
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6917	
BIRTH NO. 70 6917				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Sarah Clark			2. DATE AND HOUR OF DEATH 7-3-70 8:30 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Bolton Hill Nursing & Convalescent Center			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 501		
FULL NAME OF HOSPITAL OR INSTITUTION 90			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 418 Misquith Street					
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-10 1909	9. AGE (In years last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilson N. Carolina	
13. FATHER'S NAME Robert Williams		14. MOTHER'S MAIDEN NAME Lena Williams		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) m		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 412.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension C.V. disease (B) arteriosclerotic heart disease (C) arteriosclerosis, generalized		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year year years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/10 19 70 to 7/3 19 70 , that (I) (we) last saw the deceased alive on 7/3 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE AL MARRAS				23B. DATE SIGNED 7/4/70	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MARCH MD				23D. ADDRESS 2 E Real St Balt Md 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-8-70		24C. NAME OF CEMETERY or CREMATORY Rural Cem.	
24D. LOCATION (City, town, or county) (State) Wilson, N. Carolina		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Levi Hamilton, Wilson, N.C. Johnny O. Wilson, Balto. Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

70 6918		BALTIMORE CITY HEALTH DEPARTMENT		70 6918	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) LAVARRE, Thelma			2. DATE AND HOUR OF DEATH 7/2/70 3:45 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 704 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1724 Barnes Street		
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/7/26	9. AGE (In years last birthday) 44	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Waynesboro, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jessie Leak			14. MOTHER'S MAIDEN NAME Frances Leak		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wgt or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Warily LaVare
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Shock (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsis and/or G.I. Bleed (B) DUE TO, OR AS A CONSEQUENCE OF: U.T.I. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1 19 70 to July 2 19 70 that (I) (we) last saw the deceased alive on July 1 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Steven R. Austin, M.D.			23B. DATE SIGNED 7/2/70		23C. PHYSICIAN'S NAME (Type) Steven R. Austin, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-70		24C. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cmt.	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR E. Wilson		25D. ADDRESS 1011 Grand Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 6919		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6919	
1. NAME OF DECEASED (Type or Print) <u>JOSEPHINE HARRIS</u>			2. DATE AND HOUR OF DEATH <u>7-6-70</u> <u>10 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>KEY CIRCLE Hospice</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>501</u>		
5. SEX <u>Female</u> 6. RACE <u>Colored</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		
13. FATHER'S NAME <u>Phil Patterson</u>			14. MOTHER'S MAIDEN NAME <u>Lennie Gary</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-09-9512</u>		
18. <u>412.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last.			17. INFORMANT <u>REV. GEO. WALKER</u> ADDRESS <u>427 N Cabin St.</u>		
19. <u>0</u> DATE OF OPERATION			20A. AUTOPSY? (Yes or No) <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>25 Jan</u> 19 <u>70</u> to <u>6 Jul</u> 19 <u>70</u> that (I) (we) lost saw the deceased alive on <u>6 Jul</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>J. Hulla M.D.</u>			23B. DATE SIGNED <u>7 Jul 70</u>		
23C. PHYSICIAN'S NAME (Type) <u>J. Hulla M.D.</u>			23D. ADDRESS <u>2214 E Fayette St Baltimore MD 21231</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7-8-70</u>		
24C. NAME OF CEMETERY or CREMATORY <u>Not known</u>			24D. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1970</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		
			25C. FUNERAL DIRECTOR <u>Elroy O. Wilson</u>		
			ADDRESS <u>1000 Brantly Ave.</u>		

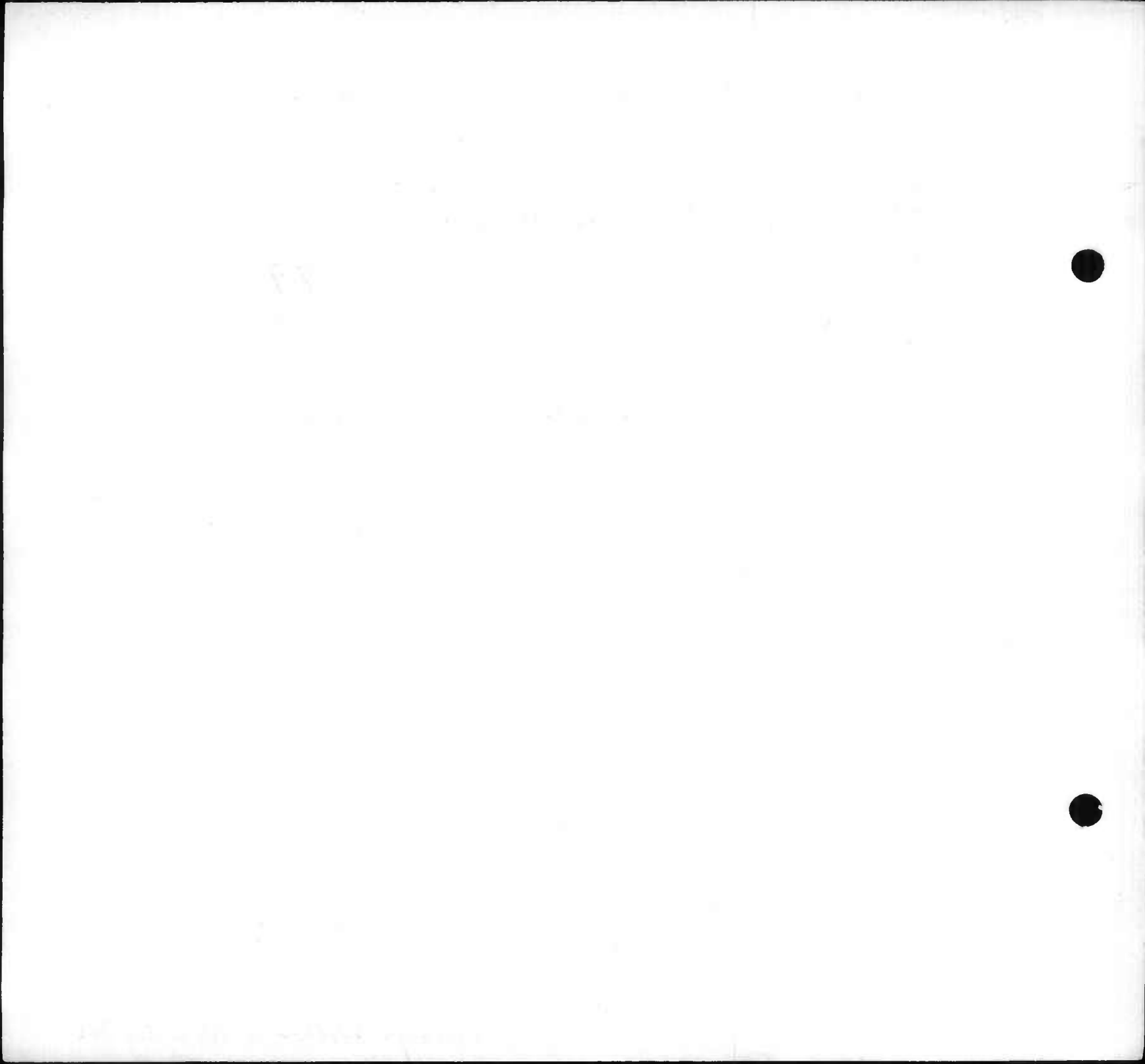
4E

405 N, Colvin St,

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

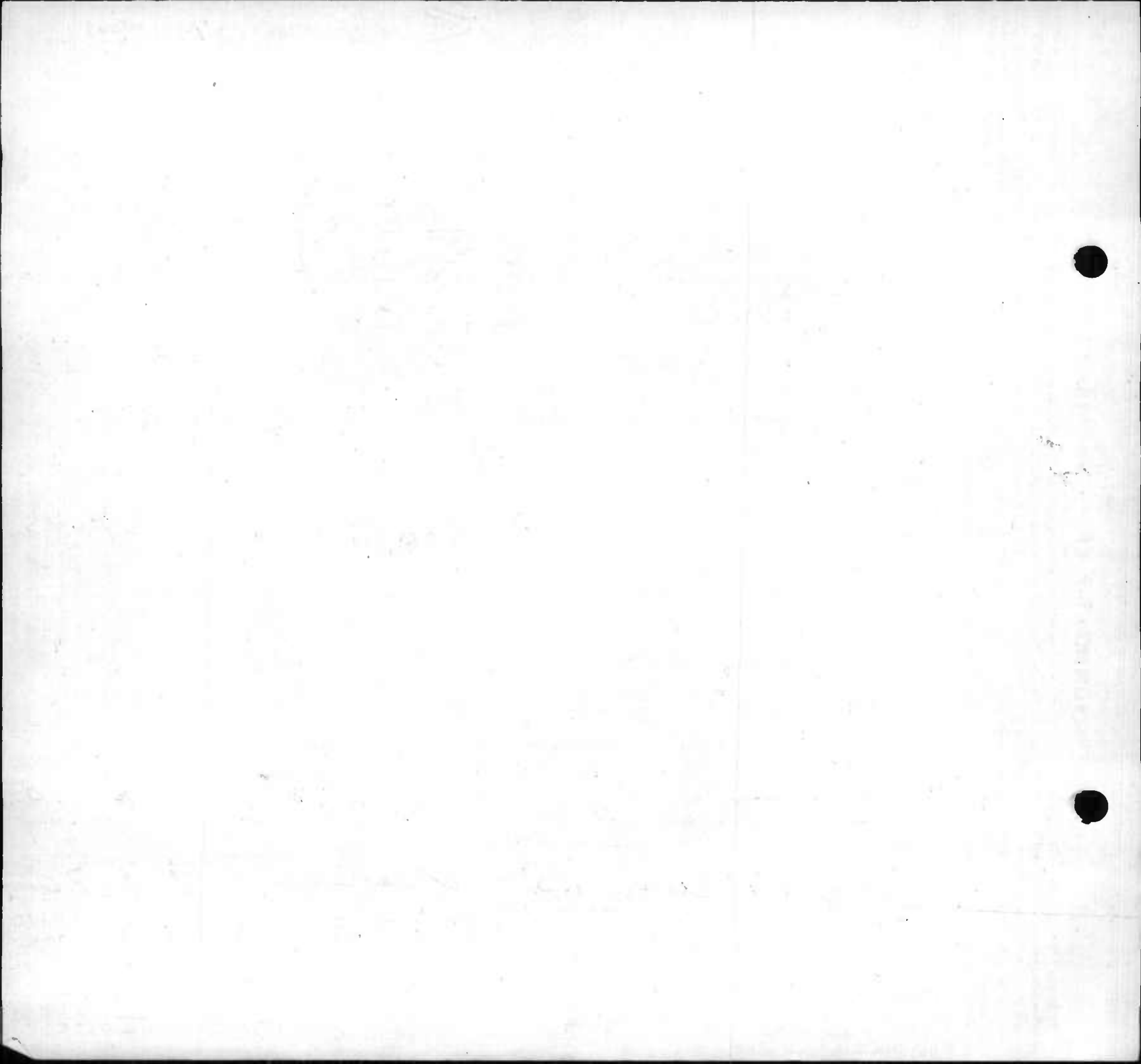
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 6920	
BIRTH NO. 70 6920					
1. NAME OF DECEASED (Type or Print) <u>Tula Keaton K</u>		2. DATE AND HOUR OF DEATH <u>7-7-70</u> <u>5 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Wilton Nursing Home</u> <u>3313 Poplar St.</u> <u>Baltimore, Md. 21216</u>		A. STATE <u>Md.</u> B. COUNTY <u>1401</u>			
5. SEX <u>F</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>11-17-1890</u>		9. AGE (In years last birthday) <u>79</u>		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Charles Kelpatrick</u>		14. MOTHER'S MAIDEN NAME <u>Jennie</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-05-5209D</u>		17. INFORMANT <u>Home Records</u>	
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.C.V.D.</u> (B) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-19-1970</u> to <u>7-7-1970</u> that (I) (we) last saw the deceased alive on <u>7-3-1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barbara Calin</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7-7-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>BARBARA CALIN</u>		23D. ADDRESS <u>831 Poplar Grove LA Balt.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-11-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Cent</u>	
24D. LOCATION <u>Arbutus</u>		24E. (City, town, or county) <u>Md</u>		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Garber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Erroy O. Wilson</u>	
				ADDRESS <u>1000 Brimley Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6921	
BIRTH NO. 70 6921		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Alex Knight</i>		2. DATE AND HOUR OF DEATH <i>July 7 1970 5³⁰ P. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>704</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1742 E Madison Street</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1742 E Madison Street</i>					
5. SEX <i>Male</i>	6. RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>8-31-1903</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>William Knight</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Chatham</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-01-4869A</i>		17. INFORMANT <i>Alfred Knight</i> ADDRESS <i>Same</i>	
18. <i>515.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Lobar Pneumonia</i> (B) <i>Silicosis</i> (C) <i>6 years</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-15-1970</i> to <i>7-7-1970</i> , that (I) (we) last saw the deceased alive on <i>7-7-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Eugene H. Owens M.D.</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7-9-70</i>	
23C. PHYSICIAN'S NAME (Type) <i>Eugene H. Owens</i>		23D. ADDRESS <i>1735 E Federal St. Balto Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-10-70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Int Oakbury Cent</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Clay O'Neil 1000 Brantley Ave</i>	



8-522

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6922

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

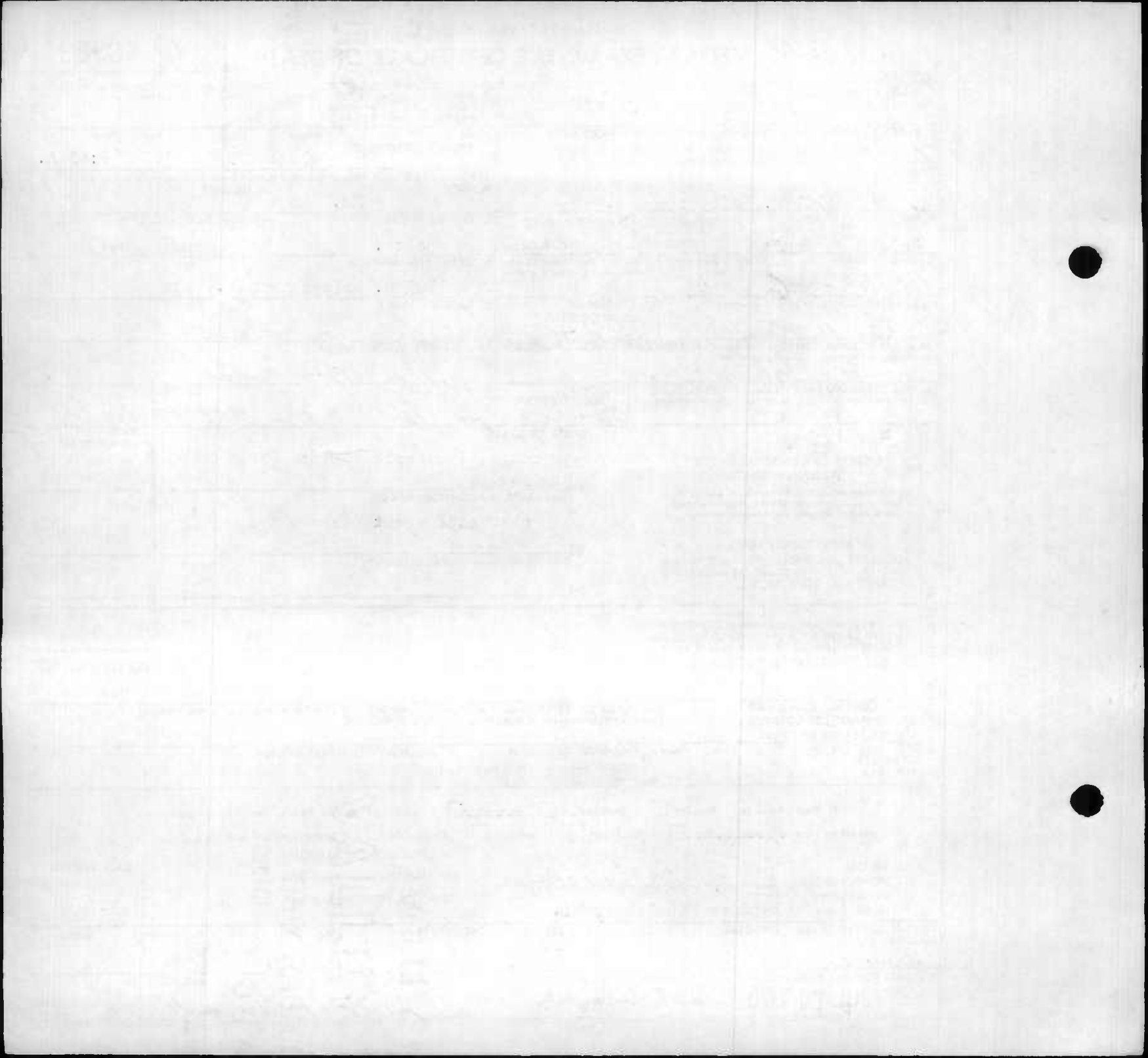
70

6922

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ANTHONY ANDREW JONES		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1701 W. Lafayette Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 7 5 1970 9:25 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Nov 23 - 1930		10. AGE (In years last birthday) 34	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew J. Jones		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman	
15. MOTHER'S MAIDEN NAME Julia McPherson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 216-34-2010		18. INFORMANT Shirley M. Jones 1048 E. Pratt St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute congestive heart failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. rheumatic heart disease OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Isidore Mihalakis, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 7-5-70			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-70	
24C. NAME OF CEMETERY or CREMATORY Arlington		24D. LOCATION (City, town, or county) (State) Arlington Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Edouardson Brantley Jr		25D. ADDRESS	



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W-235

70 6923

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

70 6923

BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) WALTER WESTMORELAND		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2326 Nevada Street		3. DATE PRONOUNCED DEAD Month Day Year July 8, 1970 Hour 10:05 P.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2543	
7. RACE Negro		C. CITY OR TOWN Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 5-20-1904		10. AGE (In years last birthday) 66	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Westmoreland		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Lucy Edwards		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No	
17. SOCIAL SECURITY NO. 238-13-5395		18. INFORMANT Lucy Westmoreland ADDRESS Same	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 7-13-70		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 7/8/70		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 7-13-70		24C. NAME OF CEMETERY or CREMATORY Arbutus Crest	
24D. LOCATION (City, town, or county) (State) Arbutus Md		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970	
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Ed Wilson 1000 Brantley Ave	

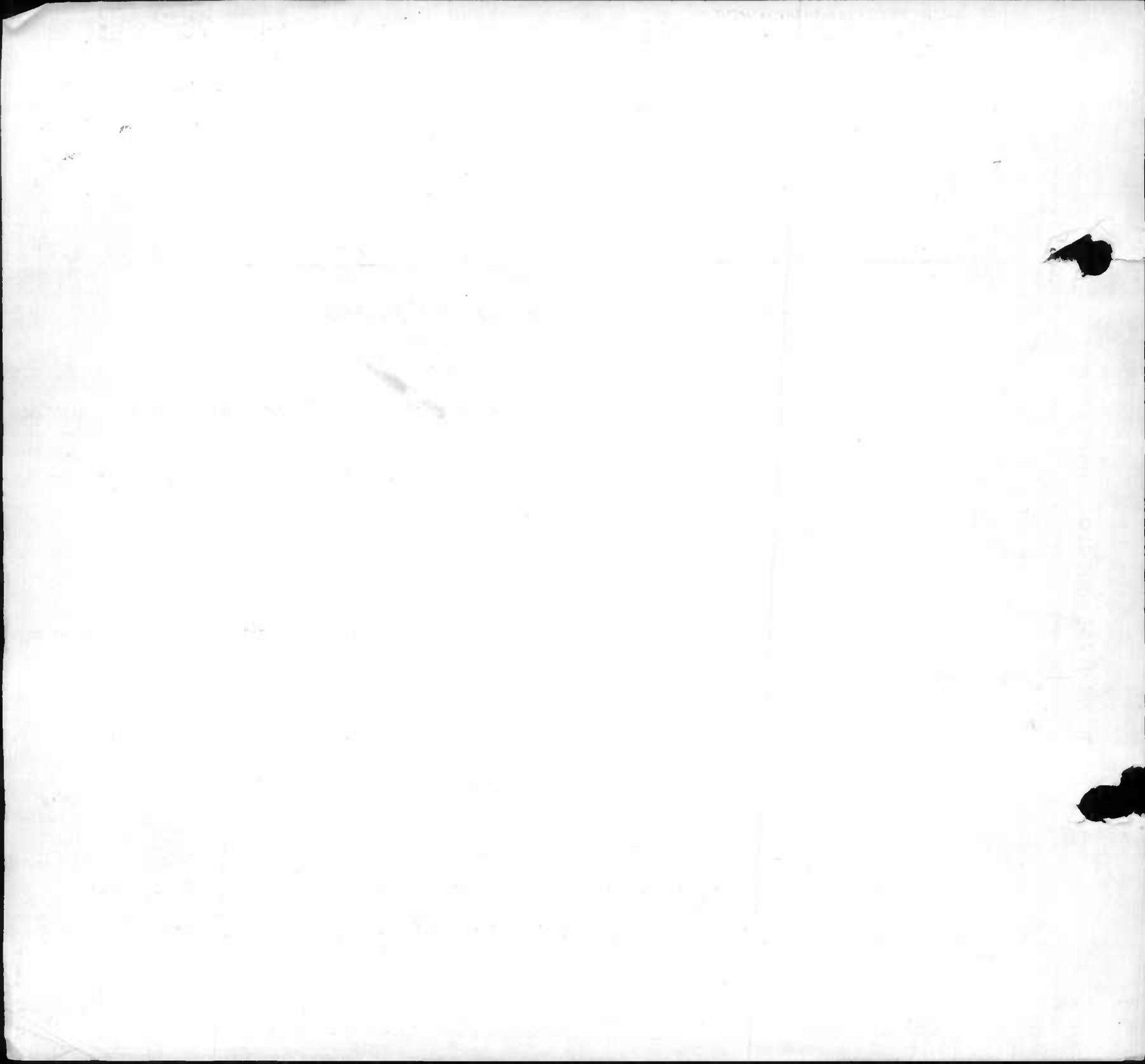
REPORT OF THE
COMMISSIONER OF AGRICULTURE
ON THE
PROGRESS OF AGRICULTURE
IN THE
UNITED STATES
DURING THE
YEAR 1909

THE CONTENTS
OF THE
VOLUME
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IN THE
UNITED STATES
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YEAR 1909

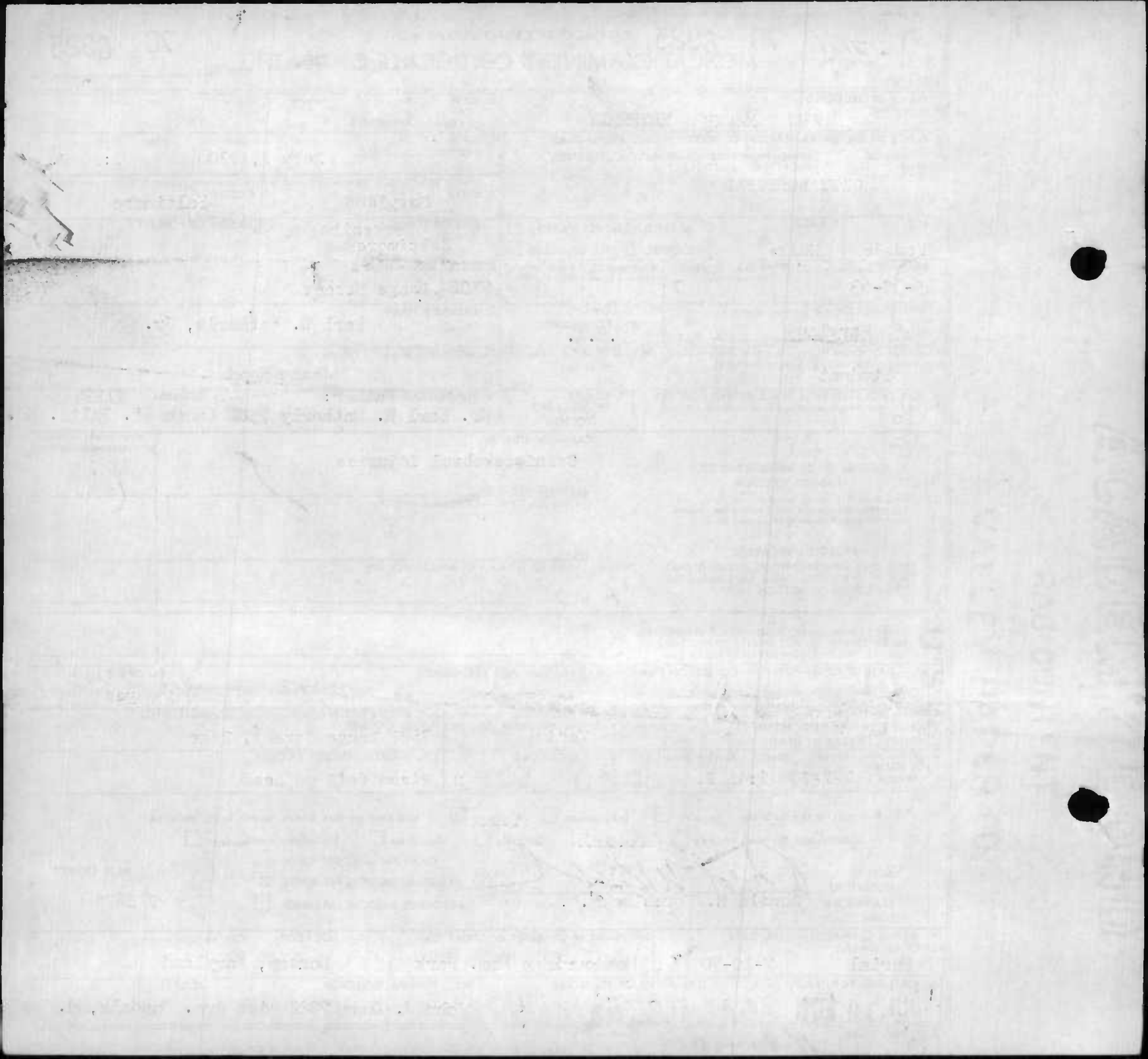
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-550 70 6924		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 6924	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>MRS KATIE CANNON</i>				7/3/70 1:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View NCC</i>				A. STATE <i>Baltimore</i> B. COUNTY <i>Harford</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>36 Cherry Garden Rd.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/2/95</i>	9. AGE (In years lost birthday) <i>75</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John A. Buntingham</i>				14. MOTHER'S MAIDEN NAME <i>Florence Gibbons</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>CARL A. LANKFORD 36 CHERRY GARDEN</i>	
18. <i>157.9</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Gangrene, left ankle several weeks</i>				CAUSE OF DEATH <i>Carcinoma pancreas</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>5-26-1970</i> to <i>7-3-1970</i> , that (I) (we) last saw the deceased alive on <i>7-2-1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. Ellsworth Cook MD.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>7.3.70</i>	
23C. PHYSICIAN'S NAME (Type) <i>E. Ellsworth Cook MD.</i>				23D. ADDRESS <i>2431 Maryland Ave Balto. MD. 21218</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7/7/70</i>		24C. NAME OF CEMETERY or CREMATORY <i>SILVER BROOK</i>		24D. LOCATION (City, town, or county) (State) <i>WILMINGTON DELAWARE</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 10 1970</i>				25B. NAME OF REGISTRAR <i>Robert E. [Signature]</i>		25C. FUNERAL DIRECTOR ADDRESS <i>UCCLEIGH FUNERAL HOME 4278 BELAIR AVE MC CREECHY FUNERAL HOME WILMINGTON DEL</i>	

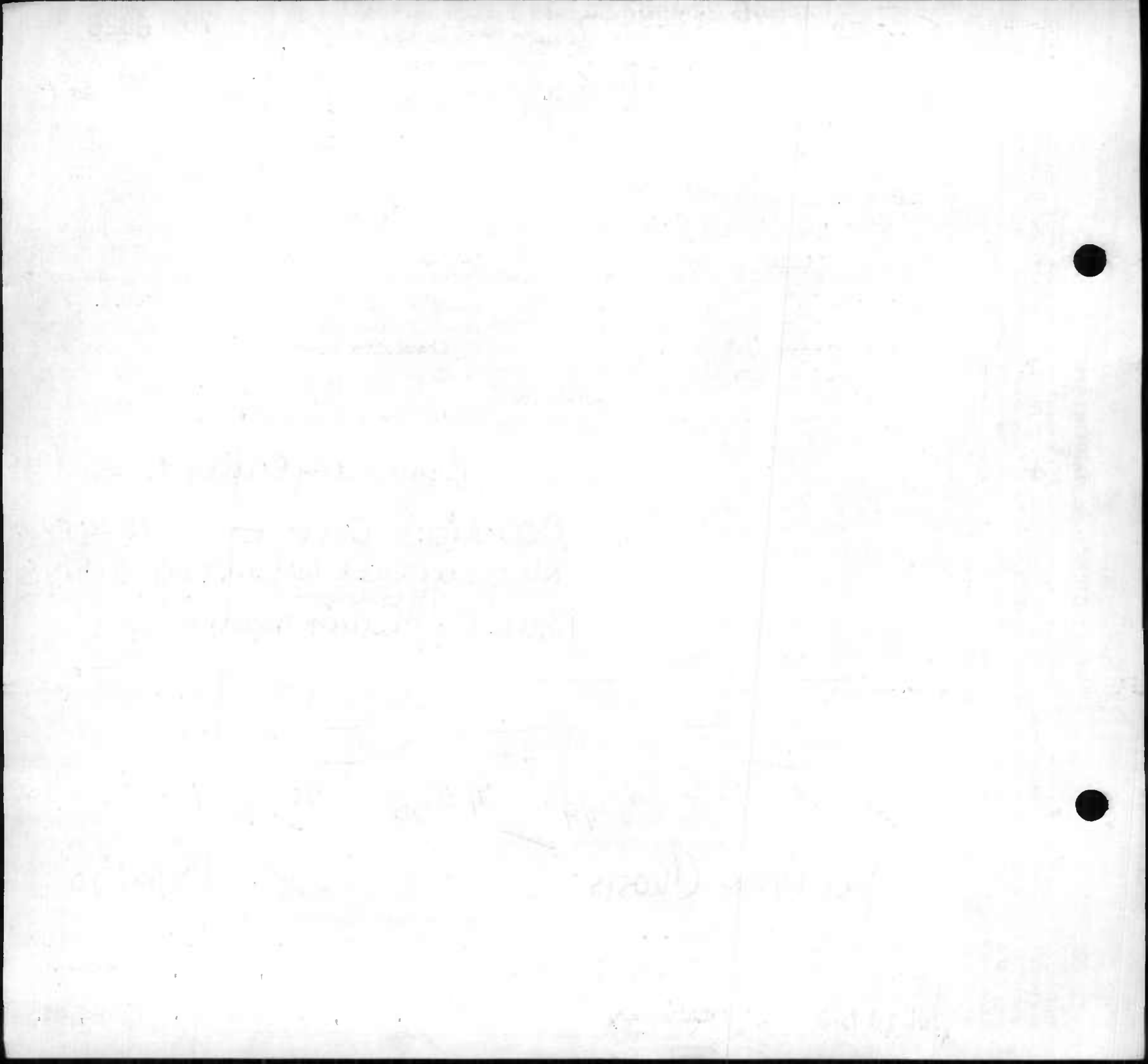


M-364 70 6925		BALTIMORE CITY HEALTH DEPARTMENT		70 6925	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) DAWN MARIE MATHERLY			2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 CITY HOSPITAL			3. DATE PRONOUNCED DEAD Month Day Year Hour July 7, 1970 3:30 P. M.		
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 5300					
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Berkshire Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 5-30-63	10. AGE (In years lost birthday) 7	11. BIRTHPLACE (State or foreign country) Maryland		E. STREET AND NUMBER 7502 Lange Street	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Earl W. Matherly, Jr.			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Joann Head	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None		18. INFORMANT Father: ADDRESS 21224 Mr. Earl W. Matherly 7502 Lange St. Balto. Md.	
19. E 716 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
CAUSE OF DEATH Cranio-cerebral Injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Yard		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 7501 Lange Street, Rear 5300	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 7-7-70 2:45 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Piano fell on head	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 7/8/70 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-70	24C. NAME of CEMETERY or CREMATORY Meadowridge Mem. Park		24D. LOCATION (City, town, or county) (State) Dorsey, Maryland
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS John J. Duda 7922 Wise Ave. Dundalk, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

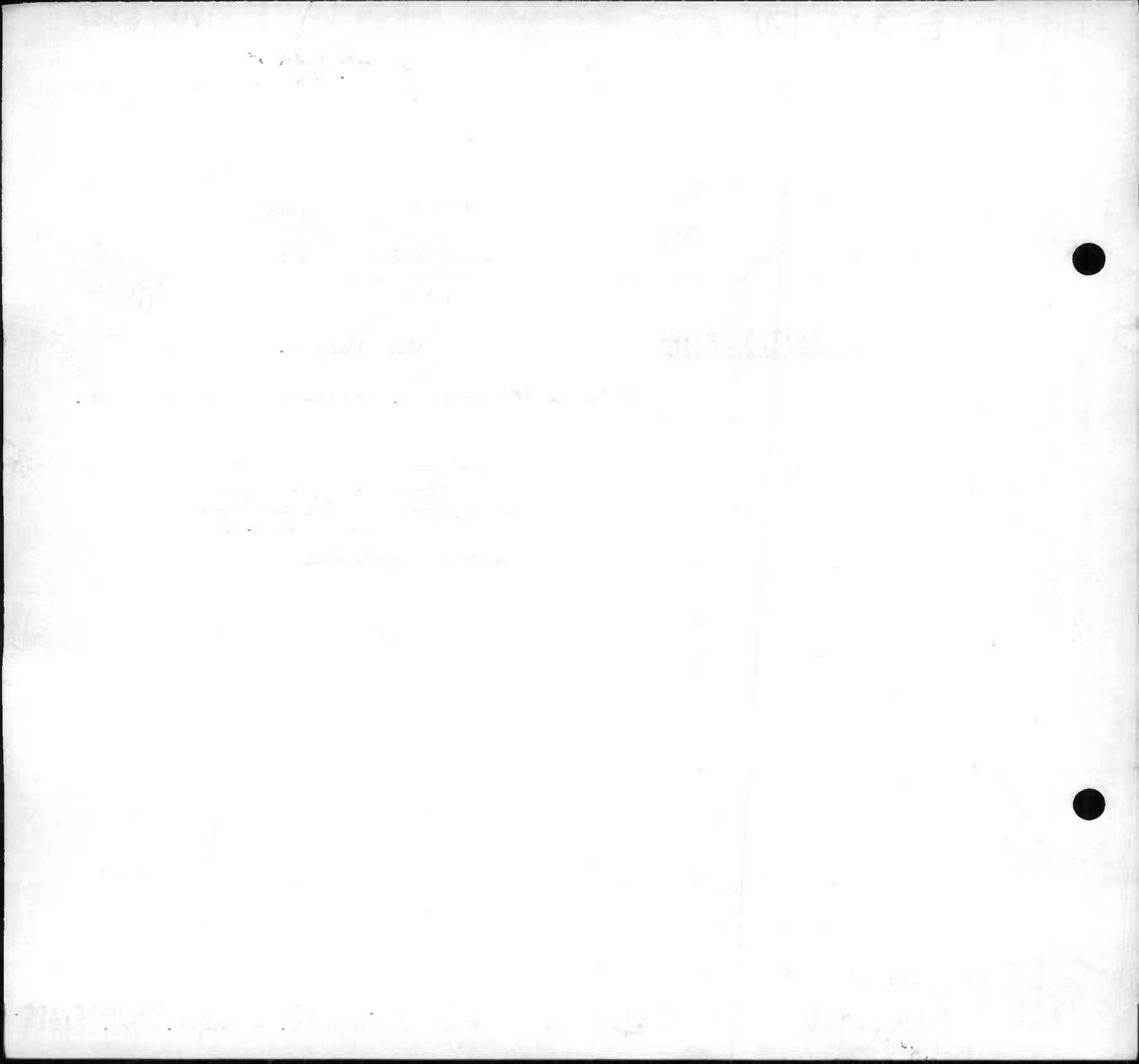
51-63-461		70 6926		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6926	
BIRTH NO.		S-552		CERTIFICATE OF DEATH X			
1. NAME OF DECEASED (Type or Print)		OLGA SIMONS		2. DATE AND HOUR OF DEATH		7/9/70 5:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		Maryland		Baltimore	
Baltimore City Hospitals		4940 Eastern Avenue		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Baltimore, Maryland		21222		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		1-25-94	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
76		Housewife		Pennsylvania		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Gunner Benson		Charlotte Lett		No		208-09-3620D	
17. INFORMANT		ADDRESS		17. INFORMANT		ADDRESS	
BCH: Records Baltimore, Maryland		21224		4940 Eastern Avenue		21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Pulmonary embolus 2 days			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Cardiac Arrest 10 minutes			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		Myocardial infarction 5 days			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Diabetes, Probable		Coronary arteriosclerosis	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/3/70 to 7/9/70, that (I) (we) last saw the deceased alive on 7/9/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED			
Joel Anne Chasis		7/9/70		7/9/70			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Joel Anne Chasis M.D.		Baltimore City Hospitals		Burial		7/13/70	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Wilcox Cemetery		Wilcox, Elk Co. Pennsylvania		Wilcox Cemetery		Wilcox, Elk Co. Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JUL 10 1970		Robert E. Taylor, M.D.		John J. Duda		7922 Wise Ave. Dundalk, Md.	



FUNERAL DIRECTOR: IMPORTANT

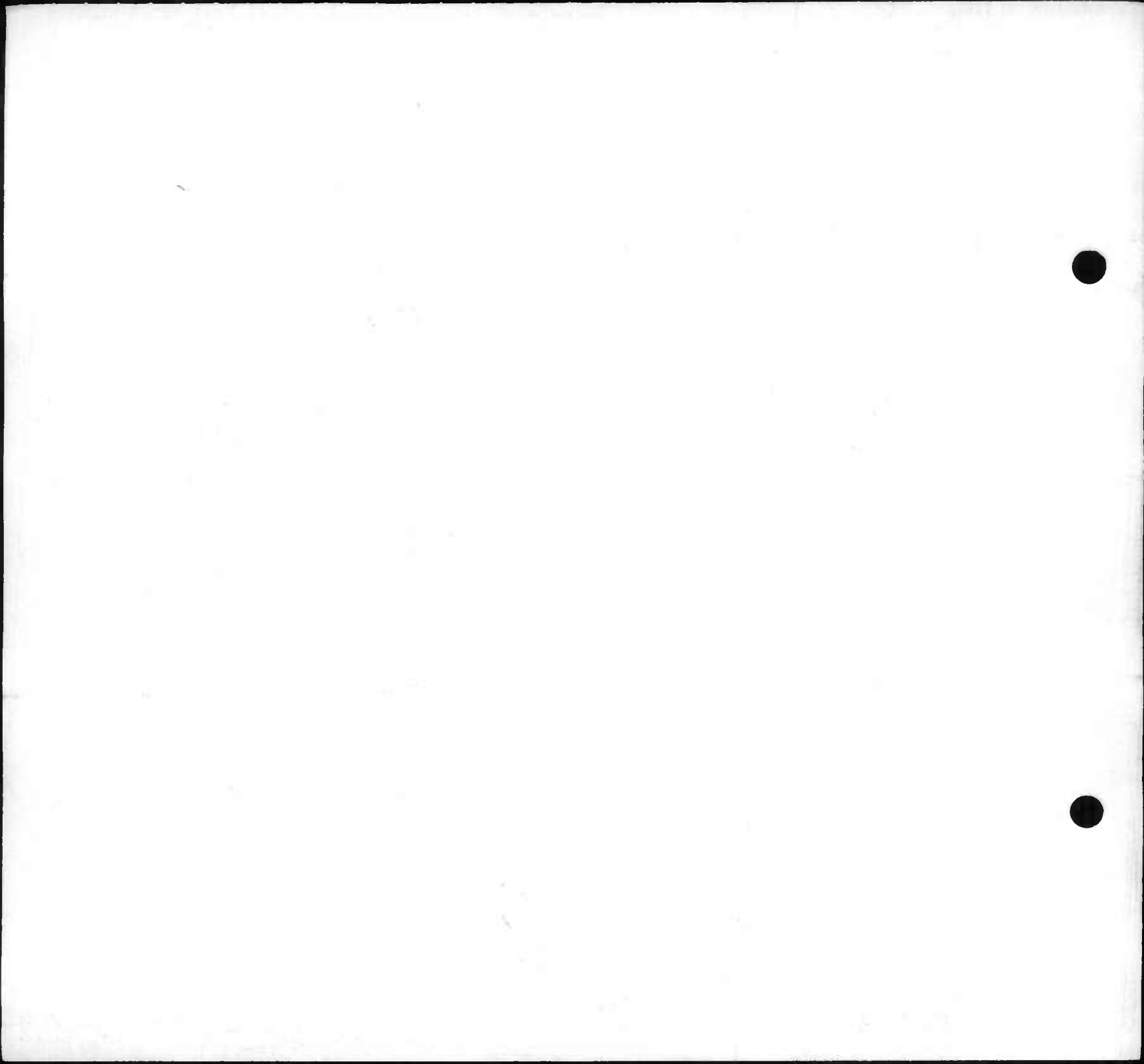
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-320 70 6927				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 70 6927	
M.E. CASE NO.				1. NAME OF DECEASED Virginia Seitz VIRGINIA SEITZ		2. DATE AND HOUR OF DEATH 7/6/1970 11.45 AM.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GEN. HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Queen Anne's C. CITY OR TOWN (If outside city limits, write RURAL and give township) Cheser. Rural D. STREET ADDRESS (If rural, give location) Marling Farms.					
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 10/6/1928	9. AGE (In years last birthday) XXX 41	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None.			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Melvin Rutter XXXXXXXXXXXXXXXXXX				14. MOTHER'S MAIDEN NAME XXX Mary E. Williams					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-28-9292		17. INFORMANT ADDRESS Edwin C. Seitz-3304 Hamilton Ave.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 347.91 + 250.9 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH A. Cerebral Edema (A) Internal cerebral artery occlusion DUE TO Brain tumor to be ruled out B. Left frontal lobe lesion all other causes excluded (B) Cerebral aneurysm DUE TO Dilatation of artery (C) Dilatation of artery				INTERVAL BETWEEN ONSET AND DEATH 7/1/1970-7/5	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity, Diabetes Mellitus									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 7/1/1970 to 7/6/1970 , that (I) (we) last saw the deceased alive on 7/6/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Mahmud J al-Brahim				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7/6/1970			
23C. PHYSICIAN'S NAME (Type) M. S. AL-IBRAHIM				23D. ADDRESS Md. Gen. Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/8/1970		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland			
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert C. Altenburg		25C. FUNERAL DIRECTOR ADDRESS Robert C. Altenburg Funeral Home Inc. 6009 Harford Rd. - Balto., Md. 21214					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

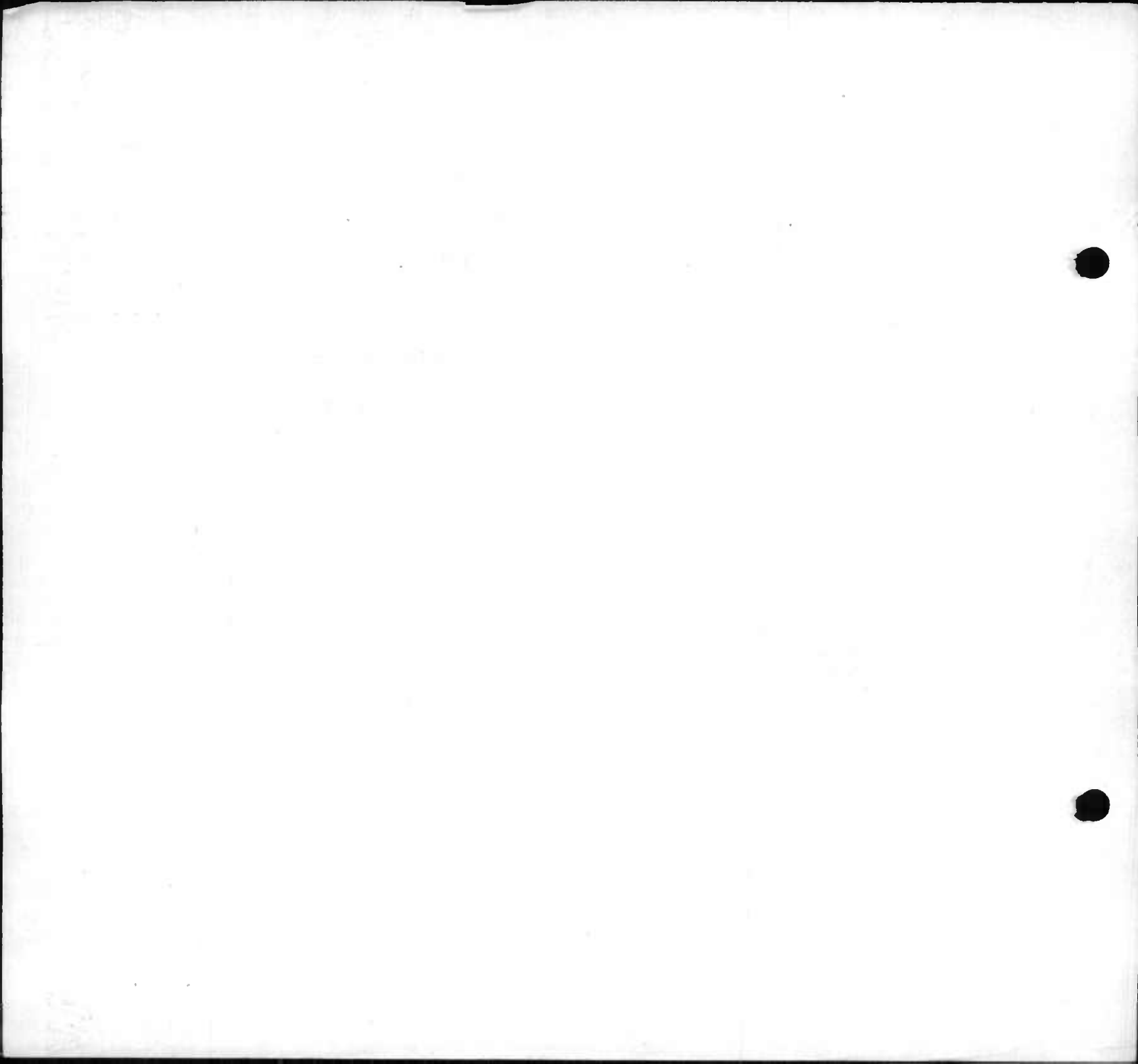
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 70 6928	
BIRTH NO. D-242 70 6928		1. NAME OF DECEASED (Type or Print) Joseph Douglass			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		2. DATE AND HOUR OF DEATH 7/7/70 11 35 P.M.			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Anne Arundel C. CITY OR TOWN 5200 Glen Burnie D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 305 Ferndale Ave		5. SEX m 6. RACE w	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-24-57		9. AGE (In years last birthday) 19	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Phillip Douglas		14. MOTHER'S MAIDEN NAME Phyllis Woodland	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Pt. chart - University Sp.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Increased intracranial pressure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Toxic and/or infectious		2-3 days	
(B) DUE TO, OR AS A CONSEQUENCE OF: central nervous system process		(C) Seizure disorders - mental retardation			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? —		22. I certify that (I) (this hospital) attended the deceased from June 5 19 70 to June 7 19 70 that (I) (we) last saw the deceased alive on June 7 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David H. [Signature], M.D.		23B. DATE SIGNED 7/7/70		23C. PHYSICIAN'S NAME (Type) —	
23D. ADDRESS —		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7-10-70		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem.		24D. LOCATION (City, town, or county) (State) Balto. A.A. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR The [Signature]	
25D. ADDRESS 237 [Signature] Ave					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

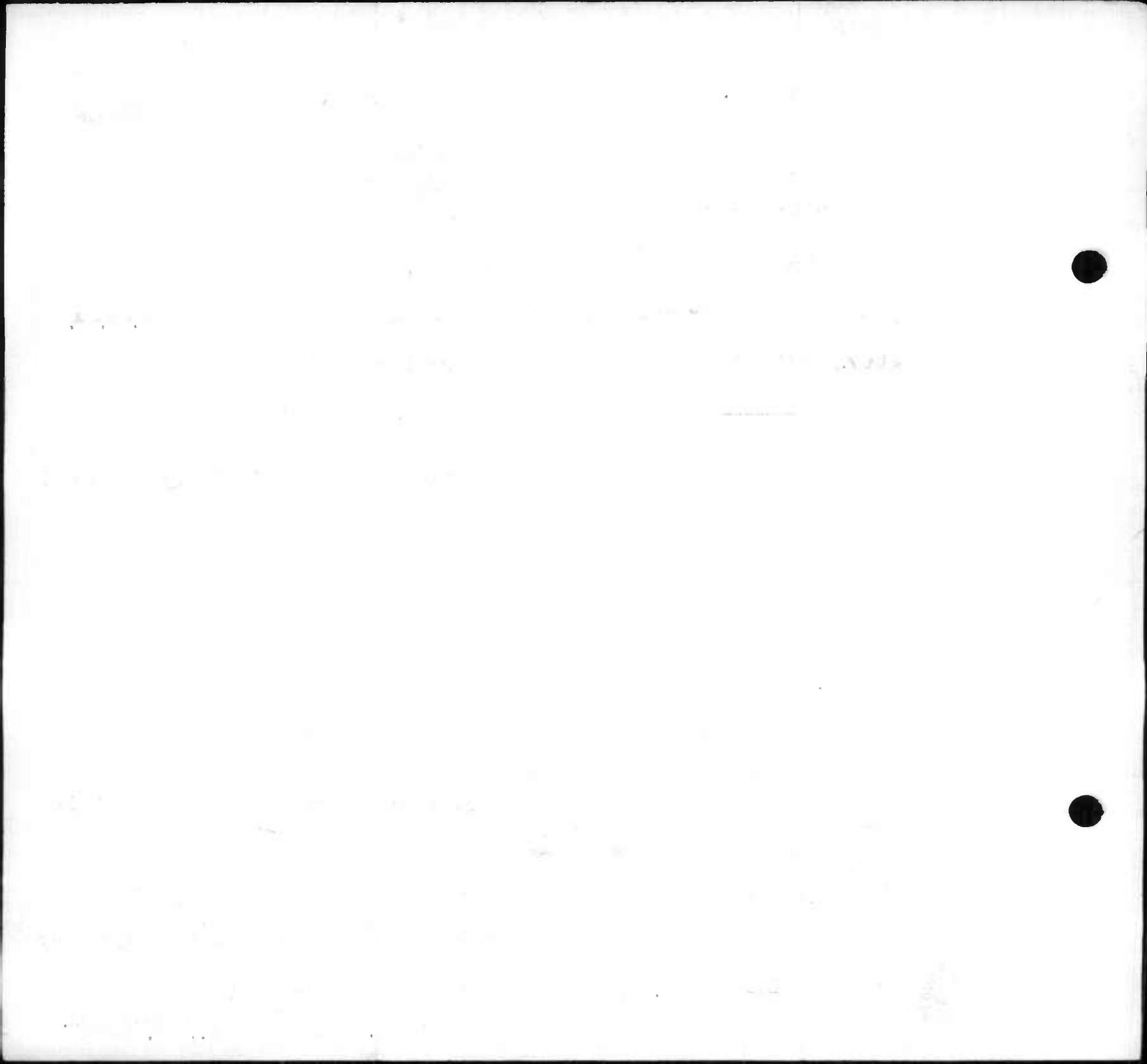
BIRTH NO. M-352		70 6929		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 6929	
M.E. CASE NO. 70 6929				1. NAME OF DECEASED (Type or Print) Myrtle H. Mattingly			
2. DATE AND HOUR OF DEATH 7/7/70				3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Nursing Home 6116 Belair Rd.			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2534		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 411 Maude Ave.		21225	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH April 18, 1905	9. AGE (In years last birthday) 65	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Jones				14. MOTHER'S MAIDEN NAME Nettie Harrison			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT William R. Mattingly		ADDRESS Same as #4	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) GENERALIZED METASTASIS				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA OF BREAST, LEFT				20. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 11/8/67		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF BREAST LEFT		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/1 19 67 to Present 19 70 , that (I) (we) last saw the deceased alive on 6/10/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE James R. Lowry				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/8/70	
23C. PHYSICIAN'S NAME (Type) IRX46 R. Kowitz				23D. ADDRESS 7017 PARK HEIGHTS AVE. BALTIMORE, MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/70		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Dorsey Howard Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 237 Patapsco Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

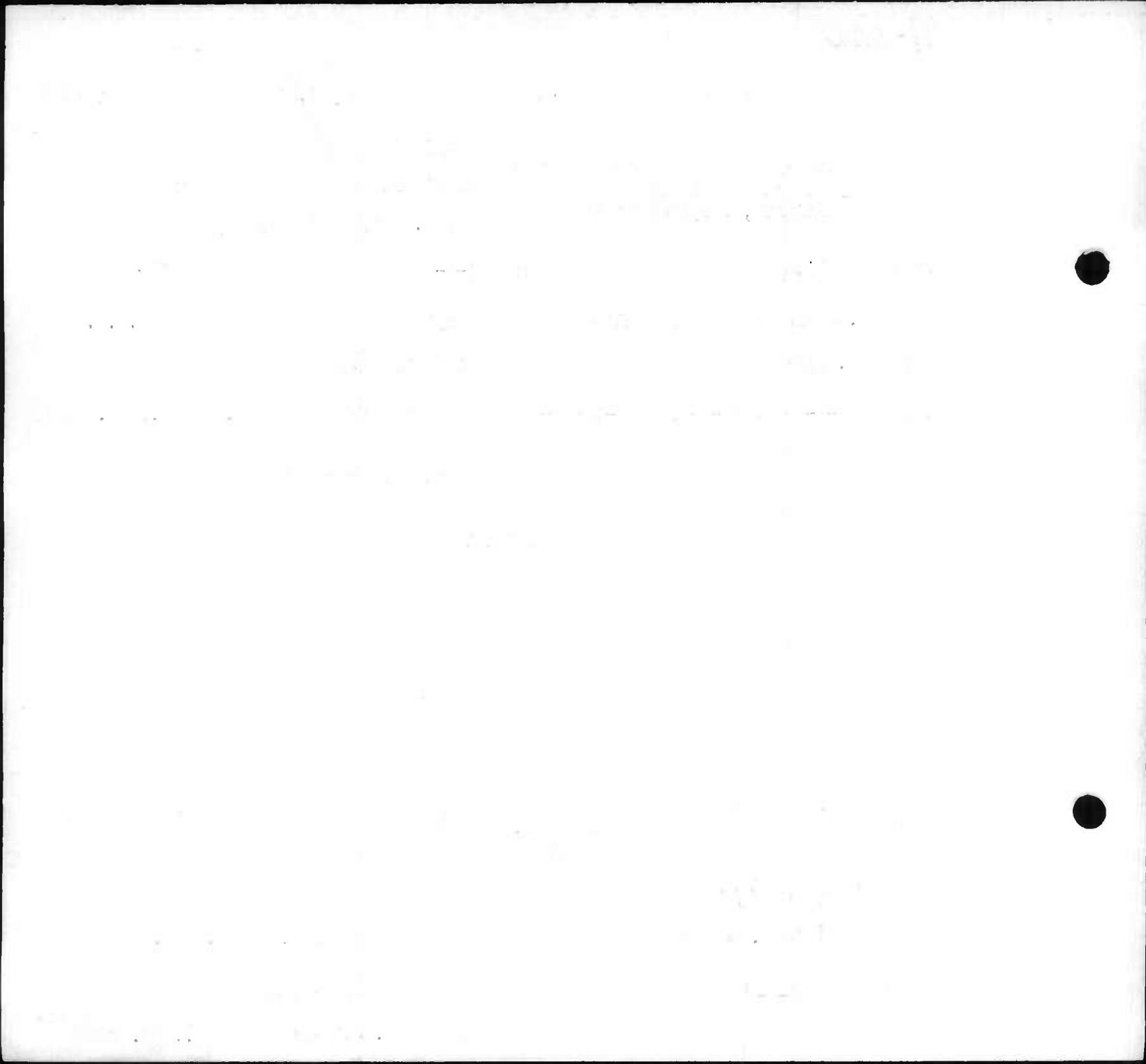
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6930</u>	
BIRTH NO. <u>S-245</u>		70 6930		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Joseph M. Seglinski</u>			2. DATE AND HOUR OF DEATH <u>July 5, 1970</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 2620 Hudson Street</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>104</u> C. CITY OR TOWN <u>Baltimore 21224</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2620 Hudson Street</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1908</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>State of Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John M. Seglinski</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>John M. Seglinski</u>			ADDRESS		
18. <u>157.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF PANCREAS 4-21-70</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) _____ (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4-21-70</u>					
19A. DATE OF OPERATION <u>NONE</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NONE</u>		20A. AUTOPSY? (Yes or No) <u>NONE</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NONE</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NONE</u>	
21D. TIME OF INJURY (Approx.) <u>NONE</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> While At Home <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NONE</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>APR. 21 1970</u> to <u>JULY 5 1970</u> that (I) was last saw the deceased alive on <u>7-5-70</u> 19 <u>70</u> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.					
23A. SIGNATURE <u>E. A. Schimunek MD</u>			23B. DATE SIGNED <u>7-7-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>EMMANUEL A SCHIMUNEK MD</u>			23D. ADDRESS <u>842 S. EAST AVE. BALTO. MD 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-9-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Stanislaus Cemetery</u>	
24D. LOCATION <u>Baltimore City, Maryland</u>		24E. NAME OF REGISTRAR <u>Robert E. Varley MD</u>			
25A. DATE RECD BY HEALTH DEPT. <u>JUL 10 1970</u>		25B. FUNERAL DIRECTOR <u>William E. Johnson</u>			
		ADDRESS <u>8521 Loch Raven Blvd. Balto., Md. 21204</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

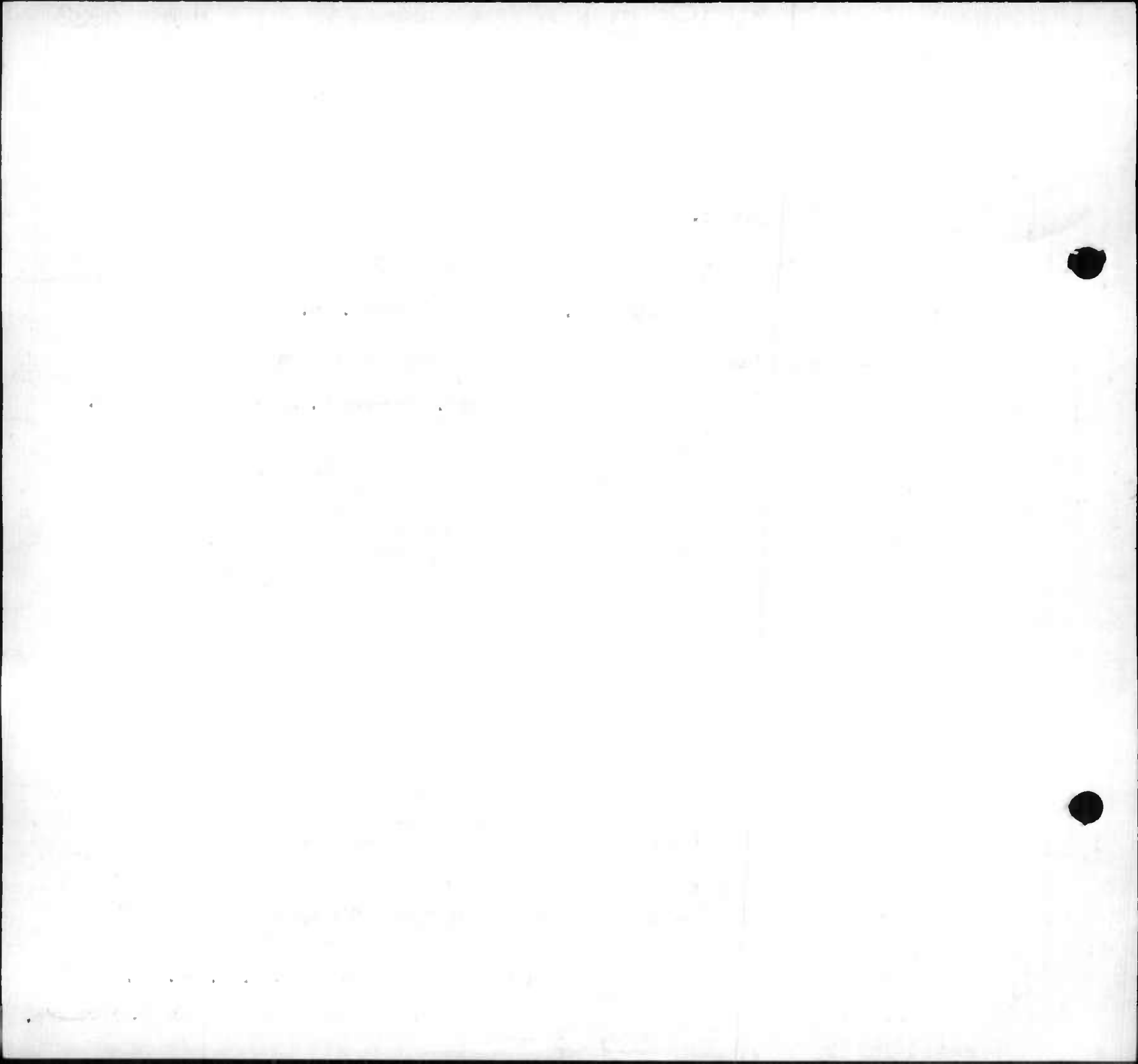
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6931</u>	
BIRTH NO. <u>M-200 70 6931</u>					
1. NAME OF DECEASED (Type or Print) <u>MOSS, HARVEY CALVIN JR.</u>		2. DATE AND HOUR OF DEATH <u>July 1, 1970</u>		11:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>23</u> <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Blvd</u> <u>Baltimore, Maryland 21218</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1202</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>229 E. University Parkway</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-4-23</u>	9. AGE (In years last birthday) <u>47</u>	11. Under 1 Yr. Months Days 12. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Heavy Eqp. Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Harvey C. Moss</u>		14. MOTHER'S MAIDEN NAME <u>Minnette Kondne</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 3-2-43 to 11-8-45</u>		16. SOCIAL SECURITY NO. <u>214-18-63-65</u>		17. INFORMANT <u>Records</u> ADDRESS <u>VAH, 3900 Loch Raven Blvd. Balto., Md. 21218</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>A S C V D</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u> (B) <u>A S C V D</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>June 30</u> 19 <u>70</u> to <u>July 1</u> , 19 <u>70</u> that (2) (we) last saw the deceased alive on <u>July 1</u> , 19 <u>70</u> and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>ES Caplan MD</u>		23B. DATE SIGNED <u>7/3/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>Ellis S. Caplan</u>		23D. ADDRESS <u>3900 Loch Raven Blvd. Balto., Md. 21218</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-8-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon National Cemetery</u>	
24D. LOCATION <u>Baltimore City, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 10 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>William E. Johnson</u>	
25D. ADDRESS <u>8521 Loch Raven Blv</u>		<u>Balto., Md. 21204</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

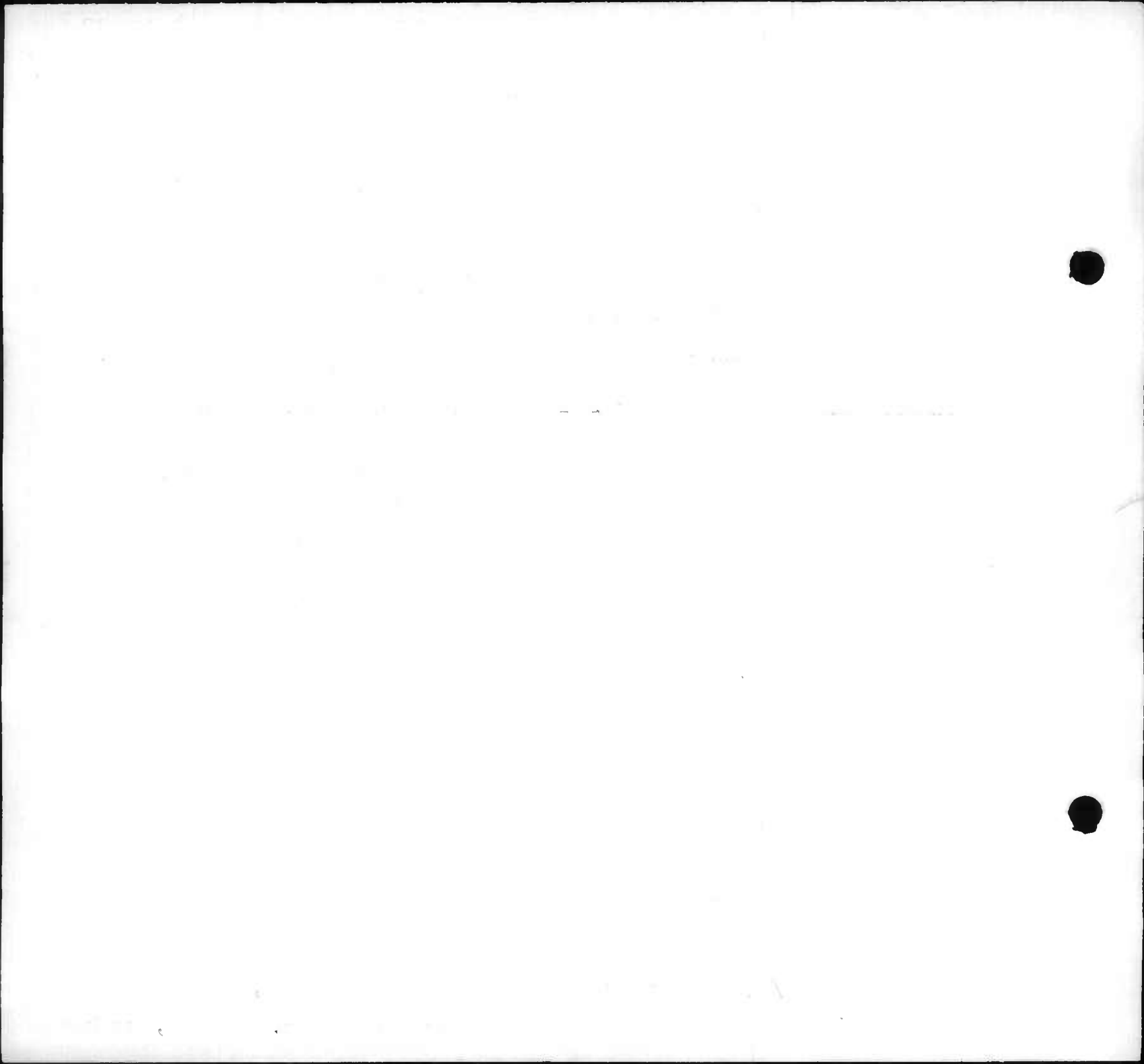
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6932
BIRTH NO. R-200		CERTIFICATE OF DEATH		
1. NAME OF DECEASED <small>(Type or Print)</small> John Henry Rice		2. DATE AND HOUR OF DEATH July 8, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1522 Boyle St.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2404 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1522 Boyle Street 21230		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 17 1893	9. AGE (In years lost birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Glass Co.		11. BIRTHPLACE (State or foreign country) Balto. Md.
13. FATHER'S NAME Unknown Rice		14. MOTHER'S MAIDEN NAME Unknown Unknown		
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> Yes # 1		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Florence M. Rice 1522 Boyle St.
18. CAUSE OF DEATH 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> coronary atherosclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Jan. 1958 to 6-23-1970, that (I) (we) last saw the deceased alive on 6-23-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE DEGREE				23B. DATE SIGNED 7-9-70
23C. PHYSICIAN'S NAME (Type) EUGENE SCHNITZER M.D.		23D. ADDRESS 3904 S. HANOVER ST. BALTIMORE, MD. 21225		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 10 70		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 10 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mc Cully		ADDRESS 130 E. Fort Ave.



FUNERAL DIRECTOR: IMPORTANT

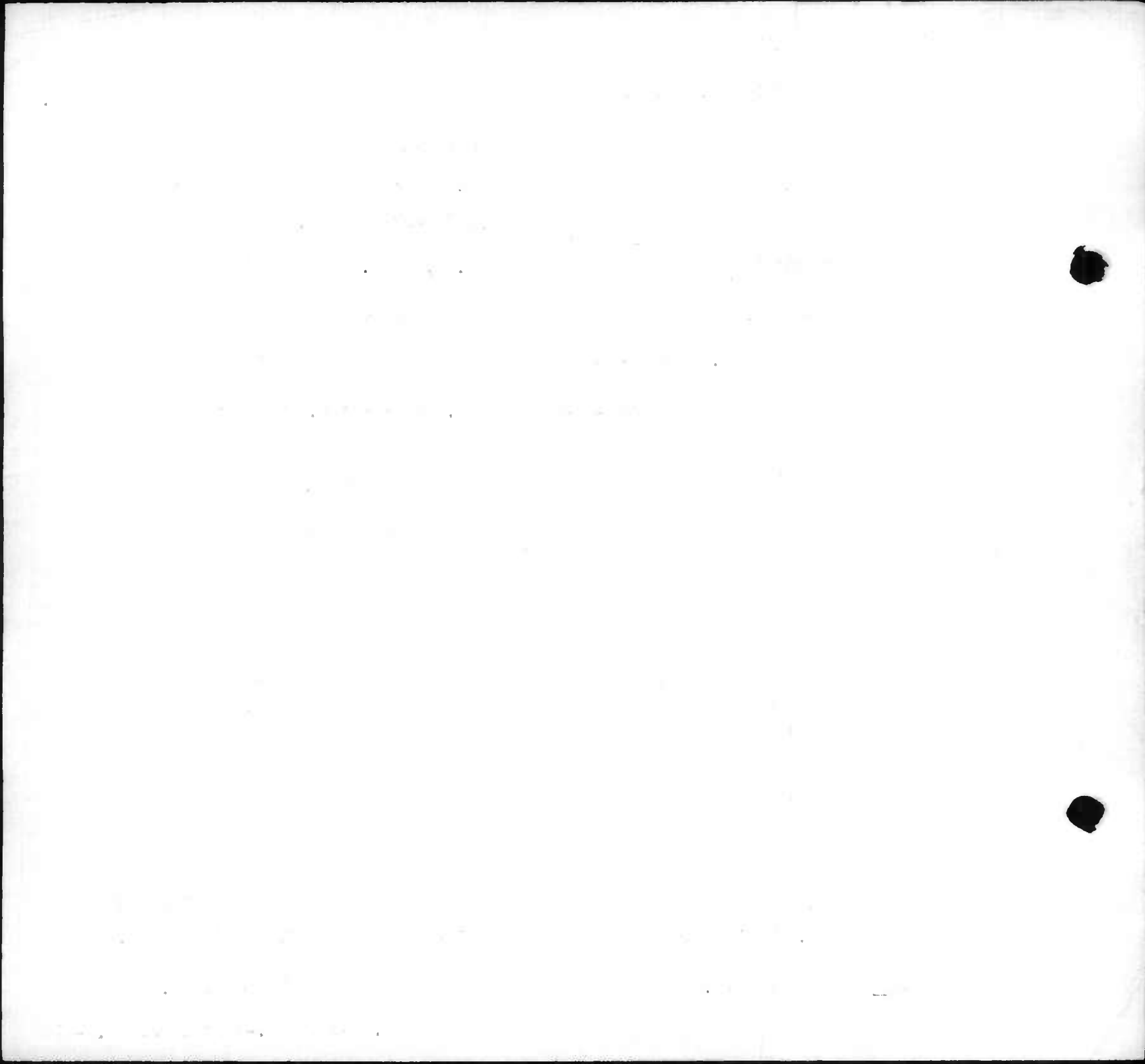
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6933		REG. NO. 70 6933	
BIRTH NO. R-543				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Nicholas J. Rinaldi Sr</i>				2. DATE AND HOUR OF DEATH <i>7/7/70</i> <i>732</i> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hosp</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2743</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3305 Batavia Ave.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>01-05-00</i>	9. AGE (In years last birthday) <i>70</i>	10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Master Plumber</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Plumber</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
12. CITIZEN OF WHAT COUNTRY <i>USA</i>							
13. FATHER'S NAME <i>Michael Rinaldi</i>				14. MOTHER'S MAIDEN NAME <i>Mary</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW 1</i>				16. SOCIAL SECURITY NO. <i>216-05-6655</i>		17. INFORMANT <i>Mrs Lillian Rinaldi</i>	
				ADDRESS <i>Same</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Epidermoid Carcinoma of lung</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>complicated by brain metastases</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes</i> (C) _____			
19. DATE OF OPERATION <i>7/02/70</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>above</i>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 18</i> 19 <i>70</i> to <i>July 7</i> 19 <i>70</i> that (I) (we) last saw the deceased alive on _____ 19 _____ and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Omar D. Crothers</i> MD DEGREE				23B. DATE SIGNED <i>7/7/70</i>		23C. PHYSICIAN'S NAME (Type) <i>Omar D. Crothers</i> MD DEGREE	
23D. ADDRESS <i>Union Memorial Hosp.</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/10/70</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Gardens Of Faith</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 10 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Talley, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J Ruck Inc.</i>		ADDRESS <i>Baltimore, Maryland</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

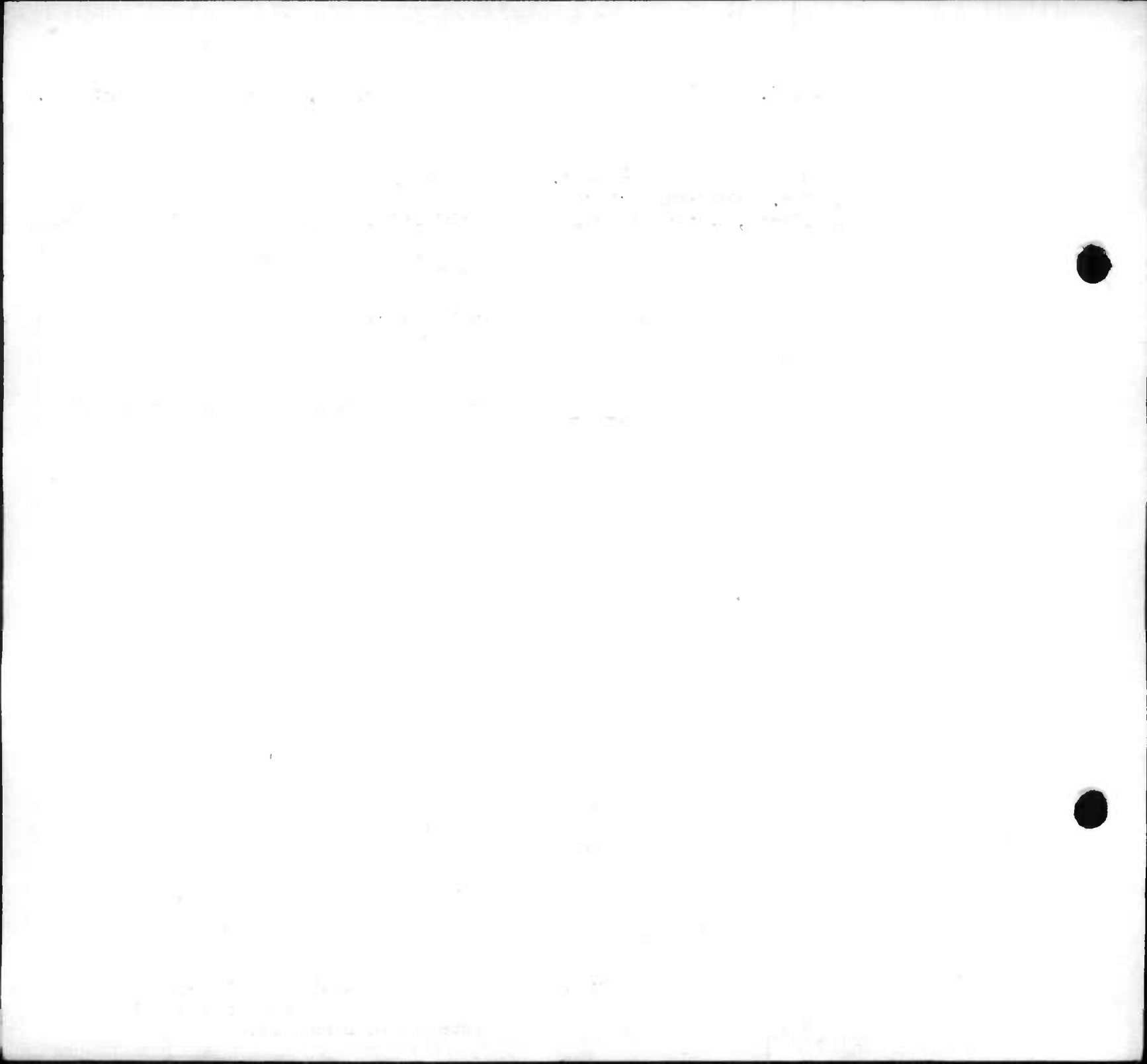
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

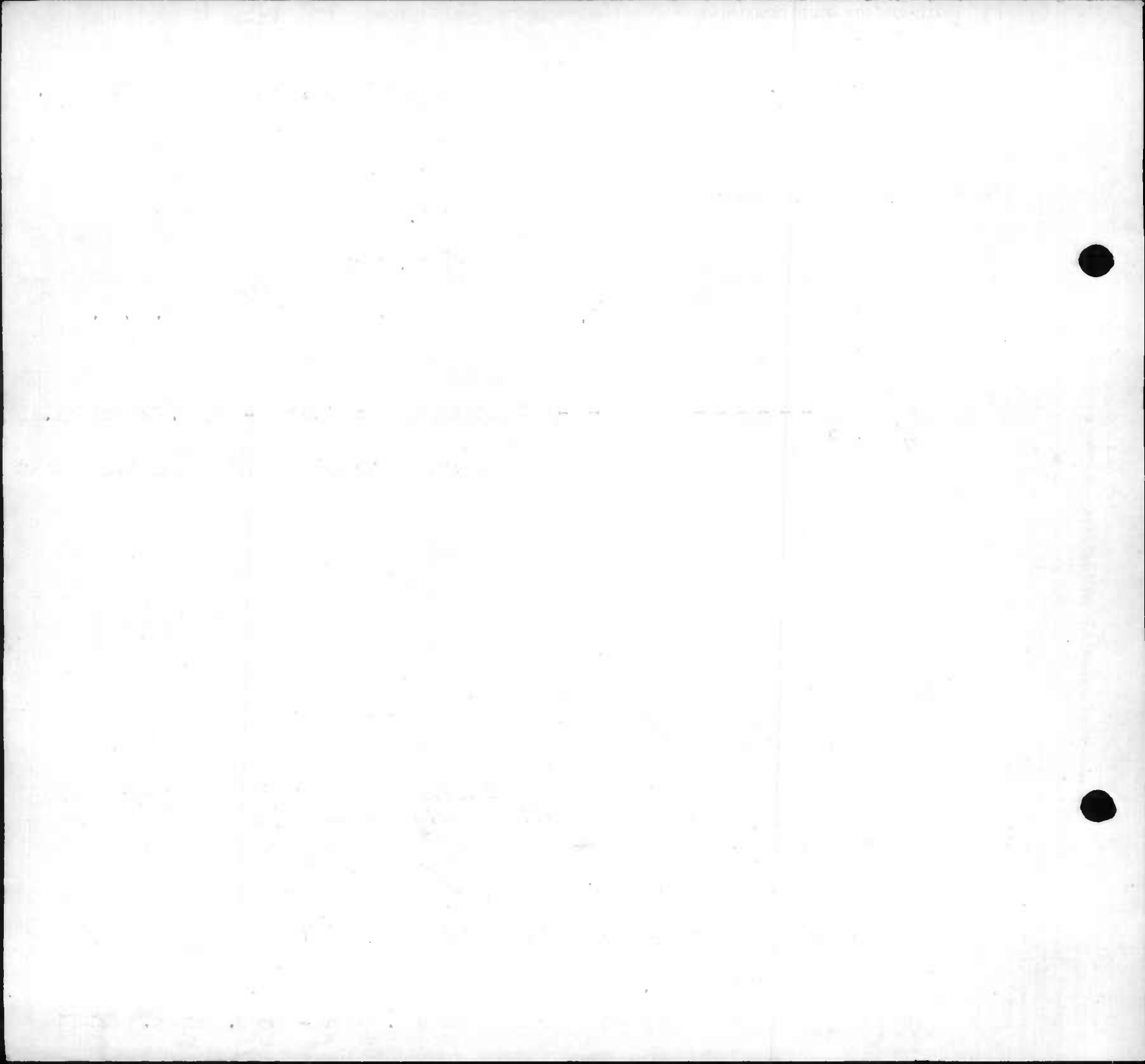
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6935</u>	
70 6935				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type as Print) <u>LEE V. DAVIS</u>				July 8, 1970 9:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 House In The Pines - Belv. 2525 W. Belvedere Avenue Baltimore, Maryland 21215</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>2717</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4804 Palmer Avenue 21215</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/94</u>	9. AGE (in years last birthday) <u>76</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Orderly</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>			13. FATHER'S NAME <u>Lee Andrew Davis</u>		
14. MOTHER'S MAIDEN NAME <u>Etta</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes W.W. I</u>		
16. SOCIAL SECURITY NO. <u>140-28-4519</u>			17. INFORMANT ADDRESS <u>Mrs. Paralee Davis 4804 Palmer Ave. 21215</u>		
18. <u>4339</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1</u> 19 <u>70</u> to <u>JULY 8</u> 19 <u>70</u> that (I) <u>two</u> last saw the deceased alive on <u>JULY 5</u> 19 <u>70</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> (did not) view the body after death.					
23A. SIGNATURE <u>Alan B Cohen MD</u>				23B. DATE SIGNED <u>7/9/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALAN B. COHEN, MD.</u>				23D. ADDRESS <u>3501 ST Paul ST</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-13-1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>1735 Harford Ave. 21215 Marshall W. Jones, Jr.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

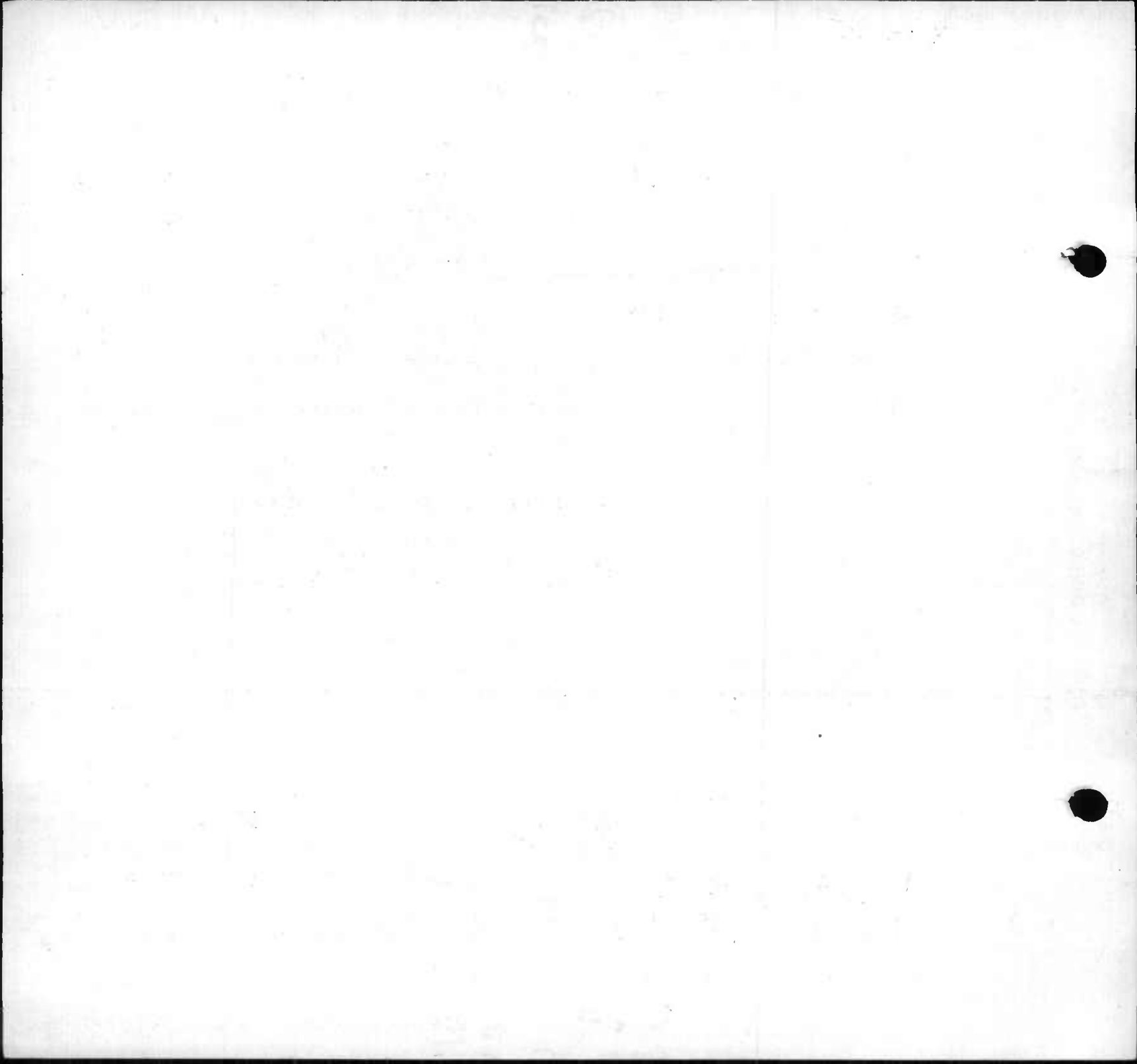
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6936</u>
BIRTH NO. <u>D-652</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>George A. Dernoga</u>		2. DATE AND HOUR OF DEATH <u>July 9th, 1970</u> <u>6:15</u> <u>p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home and Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>01-01</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>723 S. Decker Avenue #21224</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1903</u> <u>67</u>	9. AGE (In years last birthday) If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parts Shipper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>General Motors Parts Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>Casimir Dernoga</u>		14. MOTHER'S MAIDEN NAME <u>Maryanna Sumor</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-4867</u>		17. INFORMANT <u>Miss Maryanna Dernoga - 723 S. Decker Ave.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>412.3 I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROTIC HEART DISEASE 3YRS</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>2/15/66</u> 19 <u>7/7</u> 1970 , that (I) (we) last saw the deceased alive on <u>7/7</u> 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Steven B. Kaplan MD</u>			23B. DATE SIGNED <u>7/10/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>STEVEN B. KAPLAN, MD</u>			23D. ADDRESS <u>129 S. BROADWAY BALTO MD 21207</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/13/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>George A. Weber - 705 S. Ann St. #21231</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

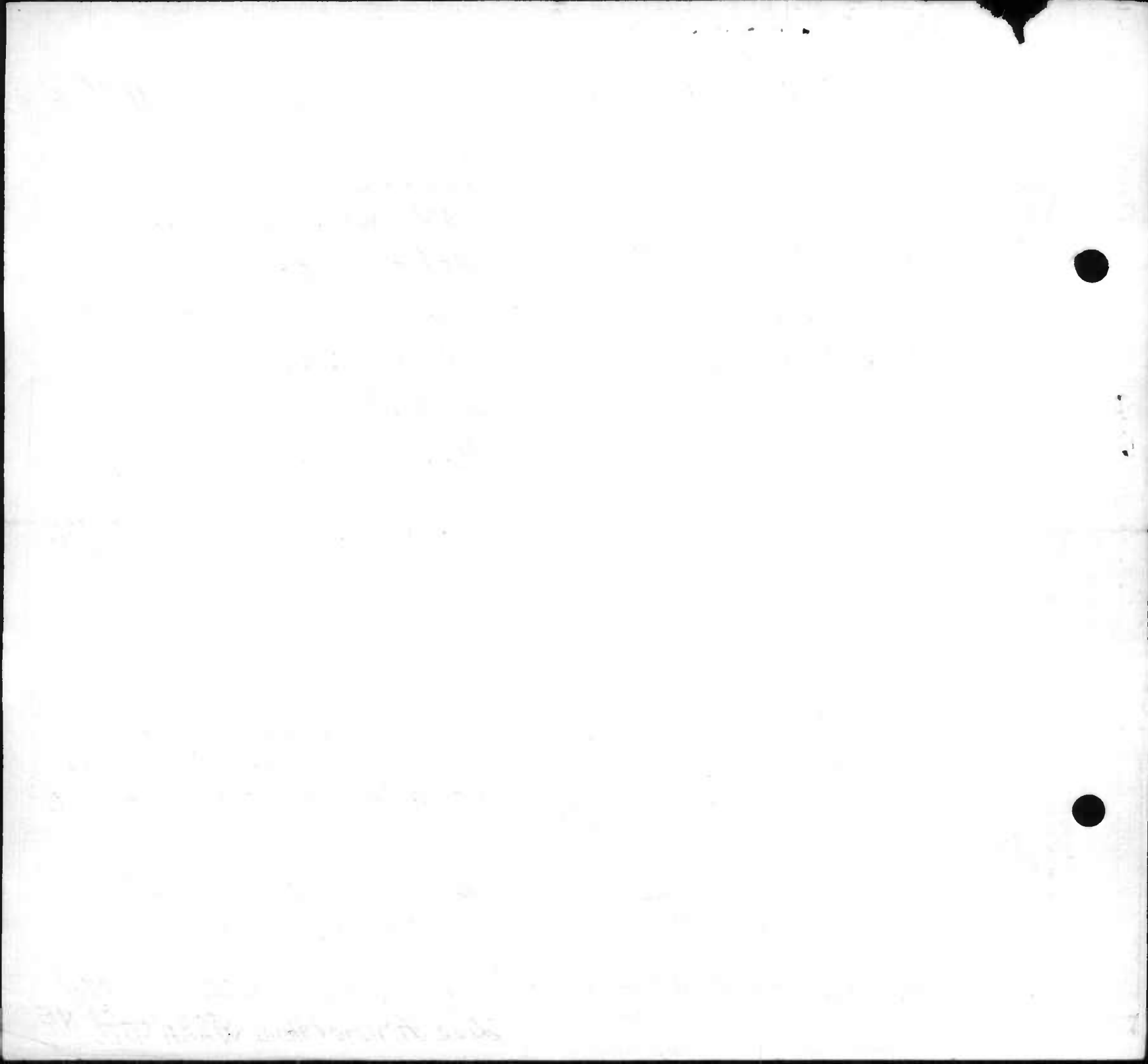
BALTIMORE CITY HEALTH DEPARTMENT									
W-625 70 6937 CERTIFICATE OF DEATH					REG. NO. 70 6937				
BIRTH NO.					2. DATE AND HOUR OF DEATH				
1. NAME OF DECEASED (Type or Print) JOSEPHINE WARCZYNSKI					7/9/70 2:00 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
3400 SOUTHERN AVE.					Md. 2743				
C. CITY OR TOWN					D. INSIDE CITY LIMITS?				
BALTO.					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER					3400 SOUTHERN AVE.				
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F.		W.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		MAR. 4, 1893		77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
SKINNER					PACKING HOUSE				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Md.					U.S.A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JOHN BEYER					LENA PAWLICKA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
No					218-0-2512				
17. INFORMANT					ADDRESS				
FRANK WARCZYNSKI					3400 SOUTHERN AVE.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)					1. Cerebral arteriosclerosis				
ANTECEDENT CAUSES					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					2. Arteriosclerosis heart				
					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					Disease - Ch failure				
					(C) 3. Genl arteriosclerosis				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
0									
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
No									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED				
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from July 1, 1965 to July 9, 1970, that (I) (we) lost saw the deceased alive on July 6, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
DONALD W. MINTZER					7/9/70				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
DONALD W. MINTZER					3009 EVERGREEN AVE BALTIMORE				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
Burial					7-11-70				
24C. NAME OF CEMETERY OR CREMATORY					24D. LOCATION (City, town, or county) (State)				
Holy Rosary Cem.					Balto. Co. Md.				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
JUL 13 1970					W. FIALKOWSKI				
25C. FUNERAL DIRECTOR					ADDRESS				
W. FIALKOWSKI					2007 EASTERN AVE.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6938		REG. NO. 70 6938	
BIRTH NO. 11-245				70 6938			
1. NAME OF DECEASED (Type or Print) Glenda McClenning				2. DATE AND HOUR OF DEATH 7/2/70 11 07 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Johns Hopkins Hospital 33				4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE Va. B. COUNTY V-43			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital				C. CITY OR TOWN Fairfax		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3301 Rockymount Rd.							
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/6/14	9. AGE (In years last birthday) 56	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Post Office Dept				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Rex Mahoney				14. MOTHER'S MAIDEN NAME Minnie Ryan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT Forest Husband Same as #4E	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral laceration ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Trauma				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Trauma (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/5/70 7/5/70	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). None							
19A. DATE OF OPERATION 7/5/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural hematoma		20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 54-00	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Lusby, Maryland		21D. TIME OF INJURY (Approx.) 7 30 70	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall down stairs		21G. DATE OF DEATH 7/5 4 1/2 19 70		21H. DATE OF DEATH 7/7 11 1/2 19 70	
22. I certify that (I) (this hospital) attended the deceased from 7/5 to 7/7 and that (I) (we) last saw the deceased alive on 7/5 and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE David M. Haines				23B. DATE SIGNED 7/7/70		23C. PHYSICIAN'S NAME (Type) David M. Haines	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 7-11-70		24C. NAME of CEMETERY or CREMATORY WELLSVILLE CEM	
24D. LOCATION (City, town, or county) (State) WELLSVILLE MO							
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970				25B. NAME OF REGISTRAR John E. Haines		25C. FUNERAL DIRECTOR Lee Funeral Home	
25D. ADDRESS 300 4 ST NE WASH DC							



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6939

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Gleny Jones

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00

2601 Greenmount Ave.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

7

7

70

10:50 a.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

904

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1-27-14

10. AGE (in years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2601 Greenmount Ave.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

M.D.

13. FATHER'S NAME

Robert A. Jones

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Flooring

14B. KIND OF BUSINESS OR INDUSTRY

Modern Floor Trans.

15. MOTHER'S MAIDEN NAME

Trane

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

MR. HAROLD JONES 1203 W. 46th

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
partial22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Partial Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

7/7/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7-9-70

24C. NAME OF CEMETERY or CREMATORY

Meadow Ridge

24D. LOCATION (City, town, or county)

Howard Co

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 13 1970

25B. NAME OF REGISTRAR

Robert E. Spitz, M.D.

25C. FUNERAL DIRECTOR

Robert E. Spitz, M.D.

ADDRESS

3615 Chestnut Ave.

1-28-11

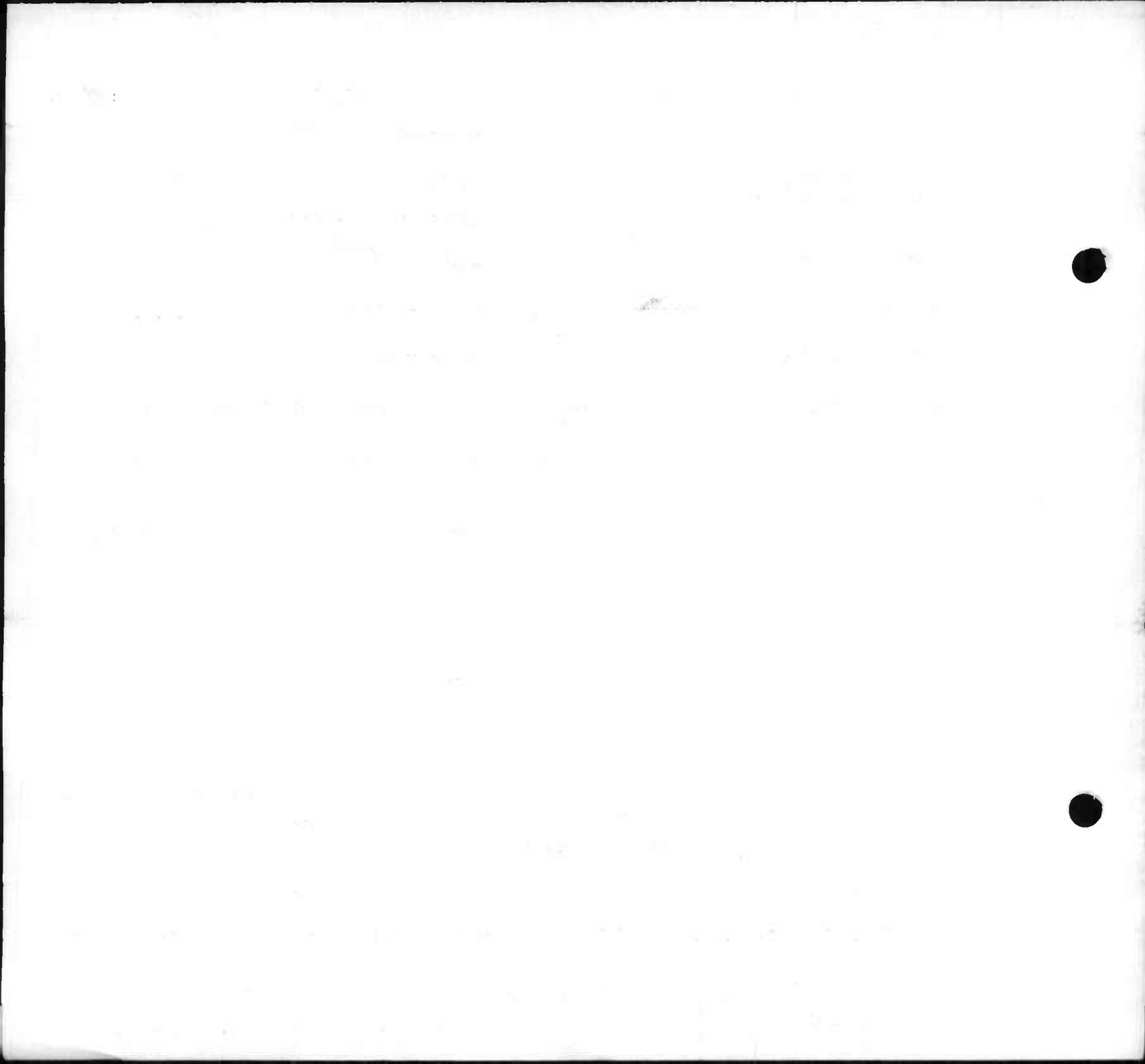
WYATT

WYATT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

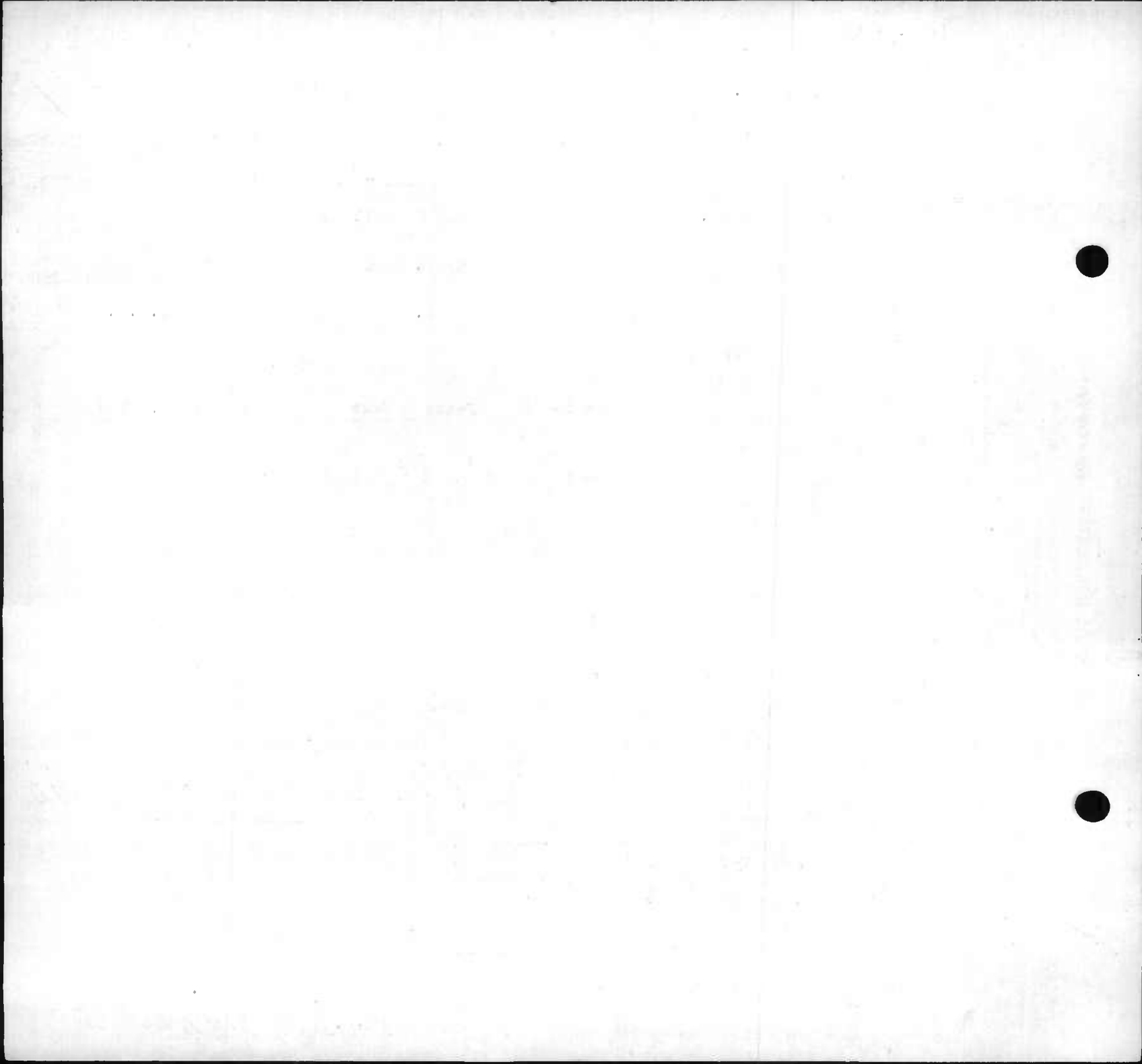
P-456		70 6940		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		70 6940	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				Robert Kenneth Plummer		July 10, 1970		4:00 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland					
USPHS Hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
3100 Wyman Park Drive				Bel Air		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER					
				Box 1403 Chur chville Road					
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		Cau		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9-4-33		36	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Machine operator				Unknown Shoe Co.		North Carolina		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Joseph B. Plummer				Wilma Young					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes 1953-1955				186-26-9913		Records, USPHS Hospital, Baltimore, Md			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Cryptococcal Meningitis				Days	
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:					
				Lymphosarcoma				Months	
				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				Yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (this hospital) attended the deceased from March 9, 1970 to July 10, 1970 that (we) last saw the deceased alive on July 10, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
<i>Gary E. Feldman</i>				July 10, 1970					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
GARY E. FELDMAN, S. A. Surg (R)				USPHS Hospital, Baltimore, Maryland 21211					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		July 13, 1970		Bel Air Memorial Gardens		Bel Air Harford Md.			
25A. DATE RECEIVED BY HEALTH DEPT				25C. FUNERAL DIRECTOR				ADDRESS	
JUL 13 1970				Howard K. McComas & Son, Abingdon, Md.					

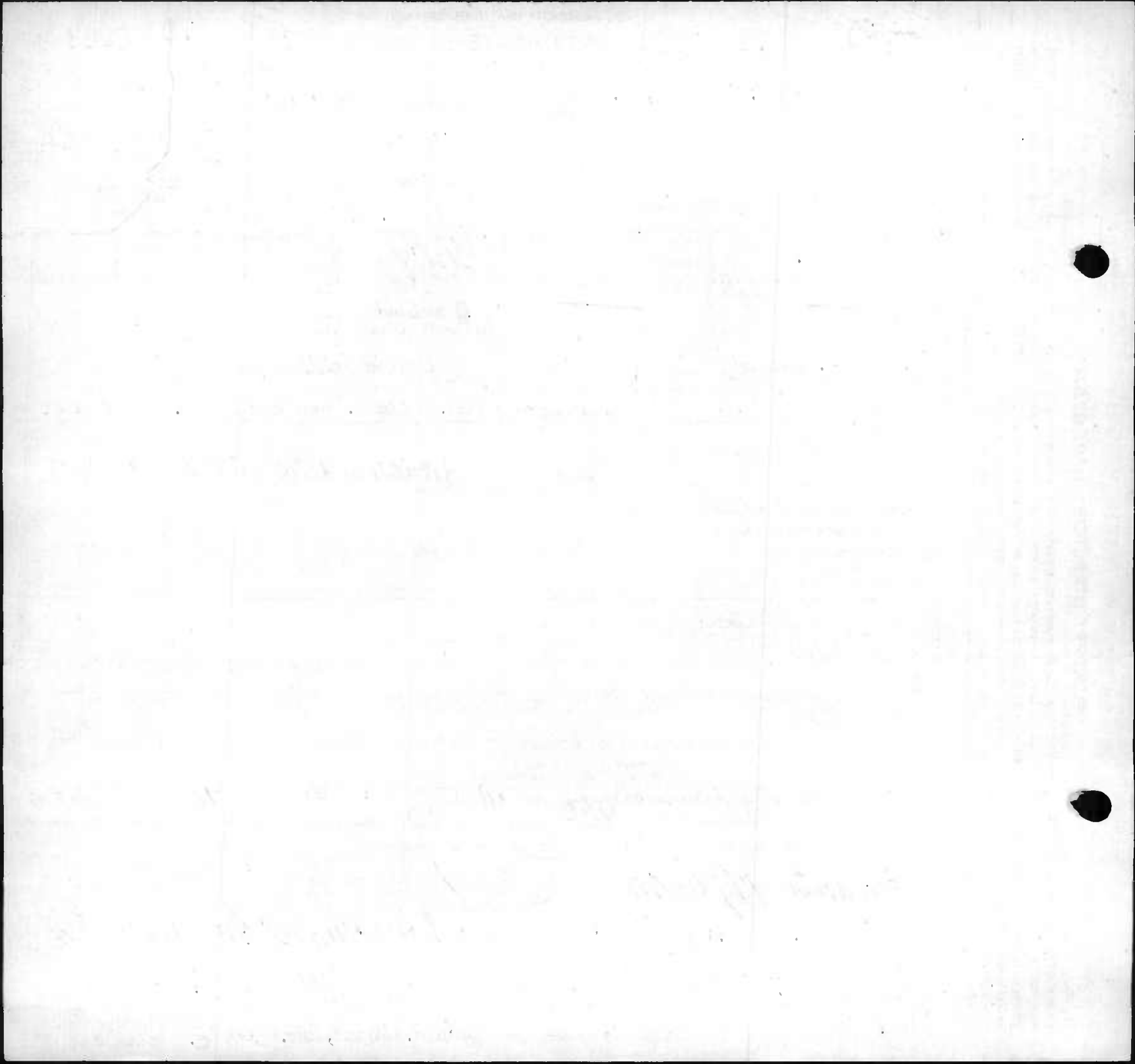


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6941</u>	
W-100 BIRTH NO. <u>70 6941</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Amelia O. Webb		2. DATE AND HOUR OF DEATH 7/9, 1970 <u>8:00 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 302 Kendall Road Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2714 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 302 Kendall Road			
5. SEX Female	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20, 1899	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstres		10B. KIND OF BUSINESS OR INDUSTRY Sewing Factory		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Webb			
14. MOTHER'S MAIDEN NAME Bateman		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-07-1875		17. INFORMANT Jesse Webb ADDRESS 40 Beechwood Hyattsville, Md. 20782			
18. 398X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Myocardial Infarction (A) IMMEDIATE CAUSE DUE TO OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>July 9</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>7-3</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Wm G Helfrich		23B. DATE SIGNED 7-9-70		23C. PHYSICIAN'S NAME (Type) Wm G Helfrich	
23D. ADDRESS 5008 ROLAND AVE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/11, 1970		24C. NAME of CEMETERY or CREMATORY Westeran		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Frank A. Senty ADDRESS 814 X 36 St	

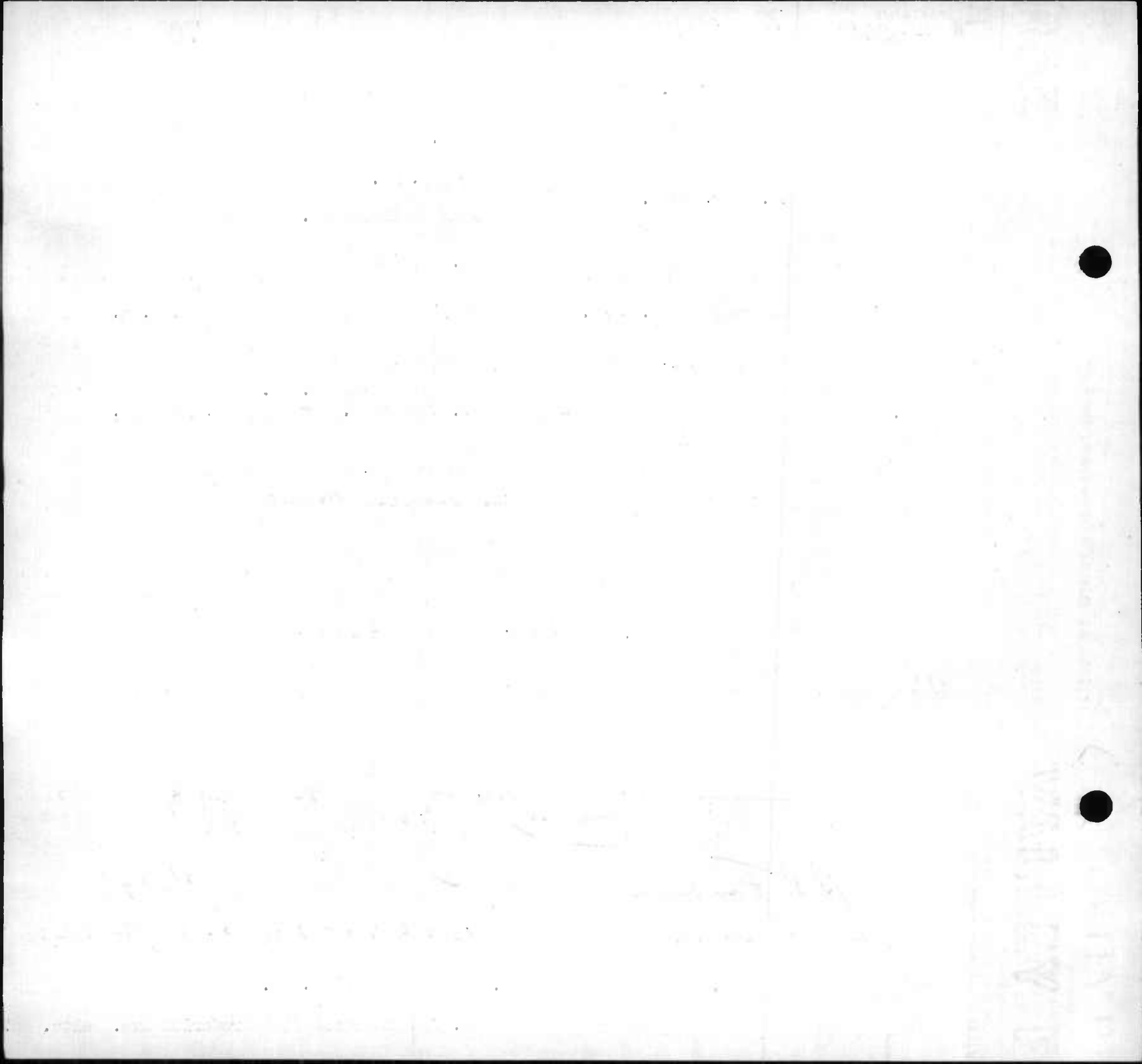




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

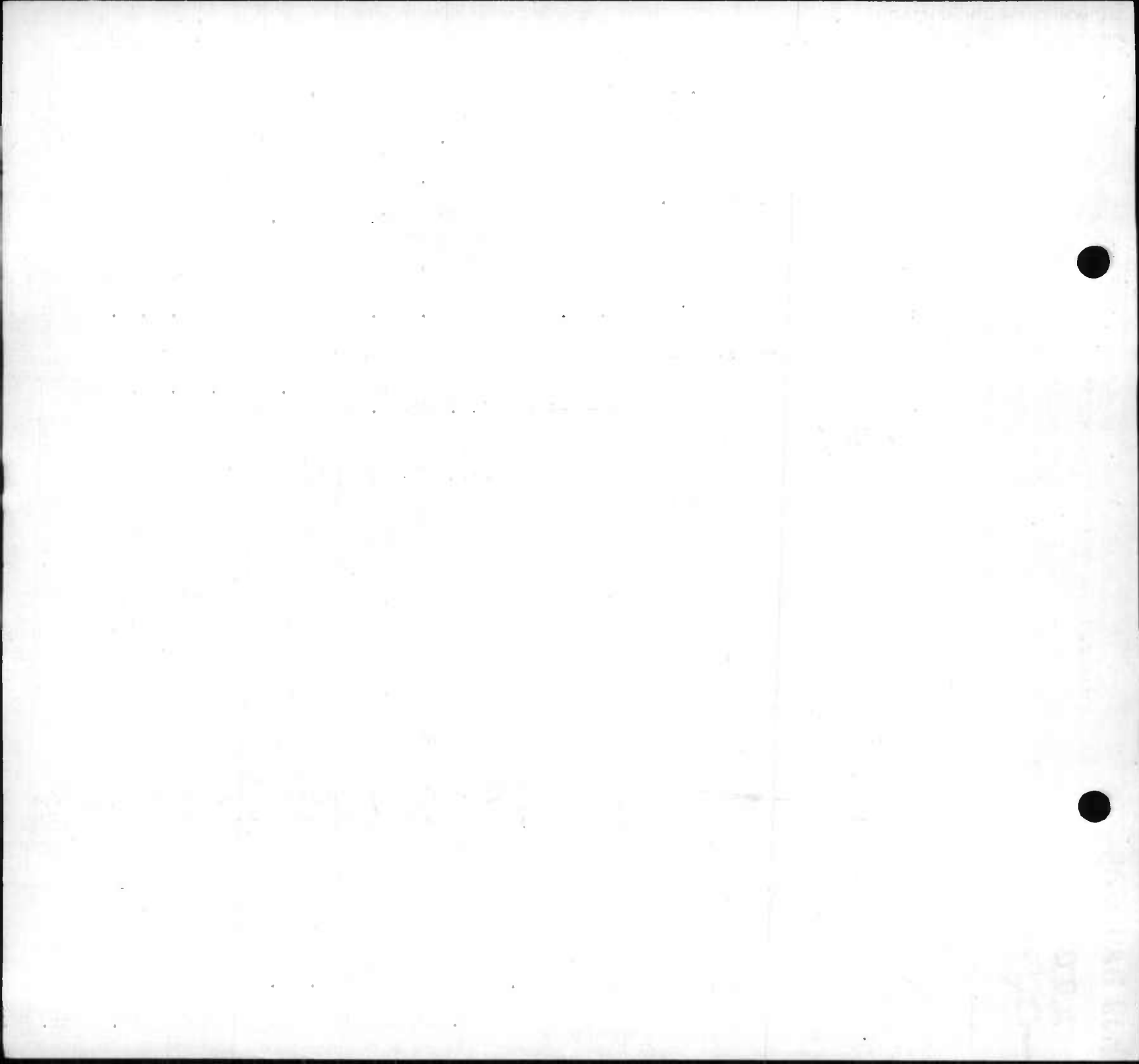
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6943</u>	
H-200 70 6943				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Madeline A. Hoch</u>				July 9, 1970 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 St. Agnes Hosp.</u>				A. STATE <u>Md.</u> B. COUNTY <u>2572</u>	
				C. CITY OR TOWN <u>Balto. Md.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2918 Mallview Rd.</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1900</u>	9. AGE (In years last birthday) <u>69</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Receptionist at Franklin Sq. Hosp.</u>			11. BIRTHPLACE (State or foreign country) <u>Bowling Green, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Jacob ? Langendoerfer</u>			14. MOTHER'S MAIDEN NAME <u>Anna ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>			16. SOCIAL SECURITY NO. <u>218-44-1938 A</u>		17. INFORMANT <u>Mr. Charles E. Hoch</u> ADDRESS <u>Balto. Md. 2918 Mallview Rd.</u>
18. <u>153.8 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>CARCINOMA OF COLON</u> DUE TO, OR AS A CONSEQUENCE OF: <u>GENERALIZED METASTASES.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>SECONDARY ANEMIA</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Mar. 24</u> 19 <u>70</u> to <u>July 9</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>June 12</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <u>H.P. Friedman</u>				23B. DATE SIGNED <u>7/11/70</u>	
23C. PHYSICIAN'S NAME (Type) <u>H.P. FRIEDMAN</u>				23D. ADDRESS <u>1319 LIGHT ST. BALTO. MD 21230</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>July 13, 1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cem.</u>	
24D. LOCATION <u>Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>G. Truman Schwab</u> ADDRESS <u>3512 Frederick Ave. Balto. Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

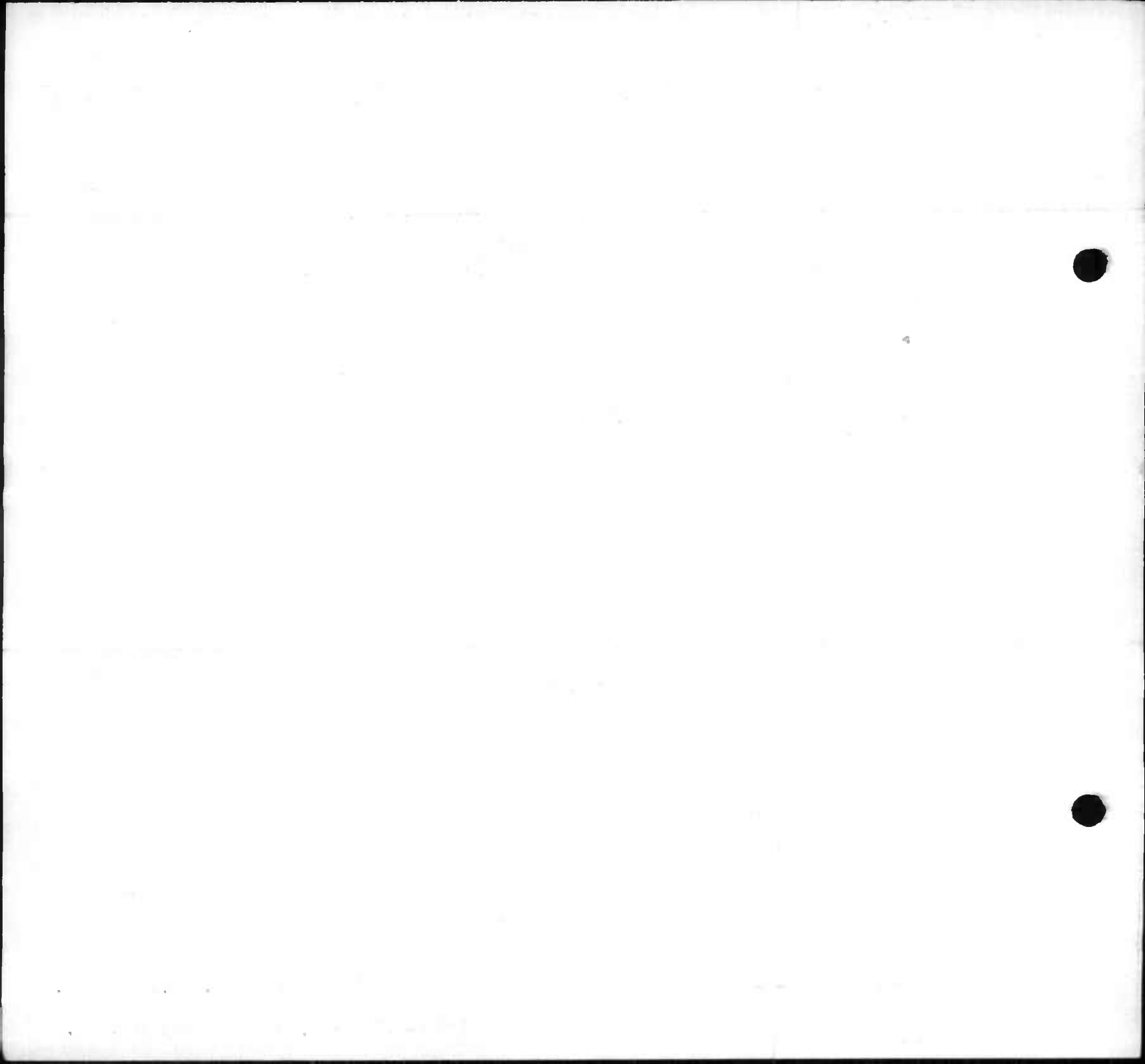
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6944</u>
W-235 70 6944				70 6944
BIRTH NO.				M.
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
William W. Westinghouse		July 10, 1970		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 2826 Georgetown Rd.		A. STATE Md.		
		B. COUNTY 2582		
		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 2826 Georgetown Rd.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1918	9. AGE (In years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY King Bros. Co.		11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Henry Westinghouse		14. MOTHER'S MAIDEN NAME Alma Kriewald		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 217-07-4612		17. INFORMANT 2826 Georgetown Rd. Balto. Md. 21230 Mrs. Rita K. Westinghouse
18. <u>4/10/9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>July 7 1970</u> to <u>July 10 1970</u> , that (I) (we) last saw the deceased alive on <u>July 7 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>William W. Westinghouse</u>		23B. DATE SIGNED 7-11-70		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS G. Truman Schwab 3512 Frederick Ave. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 13, 1970		24C. NAME OF CEMETERY or CREMATORY Moreland Cem.
24D. LOCATION Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

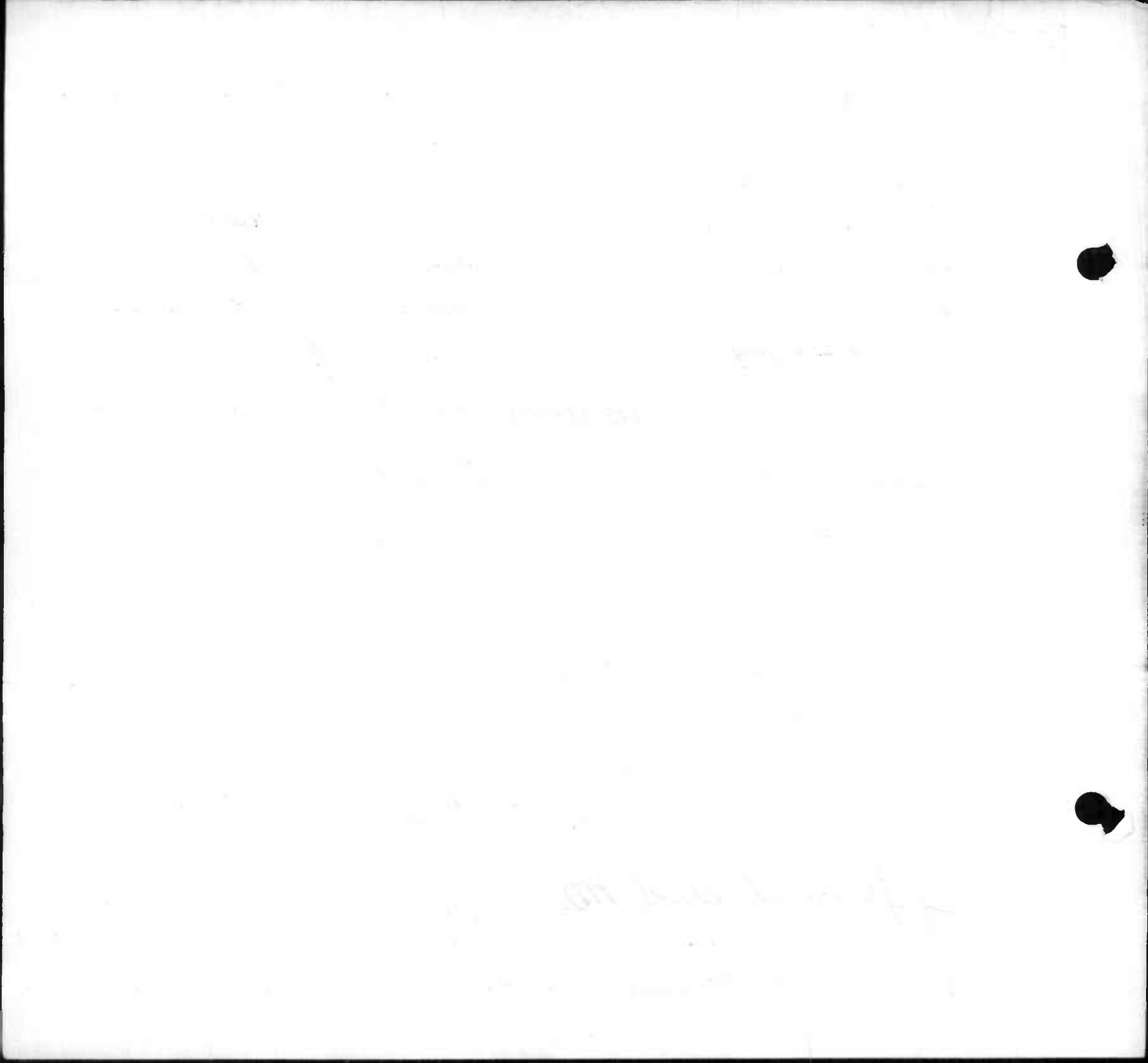
T-500 70 6945		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6945	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ODESSA R. Tawney</u>		2. DATE AND HOUR OF DEATH <u>Jul-6-70</u> <u>6:05 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt Co.</u>		53-00	
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University of Md. Hospital</u>		C. CITY OR TOWN <u>Upperco</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>Trenton Road</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-18-56</u>	9. AGE (In years last birthday) <u>13 years</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ud.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Thomas Tawney</u>		14. MOTHER'S MAIDEN NAME <u>HELEN ODESSA Smith</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HOSPITAL CHART</u>	
18. <u>23811</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Thalamic Tumor</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>Jul.</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ventriculogram</u>		20A. AUTOPSY? (Yes or No) <u>Head only.</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Jun-27-</u> 19 <u>70</u> to <u>Jul-6-</u> 19 <u>70</u> . that (I) (we) last saw the deceased alive on <u>Jul-6-</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ordover Ud.</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>Jul-6-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jorge R. Ordover MD.</u>		23D. ADDRESS <u>University of Md. Hospital BALMD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-9-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Trenton Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Upperco, Balto. Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Tipton-Eline Fun. Home</u>	
				ADDRESS <u>Hamstead, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

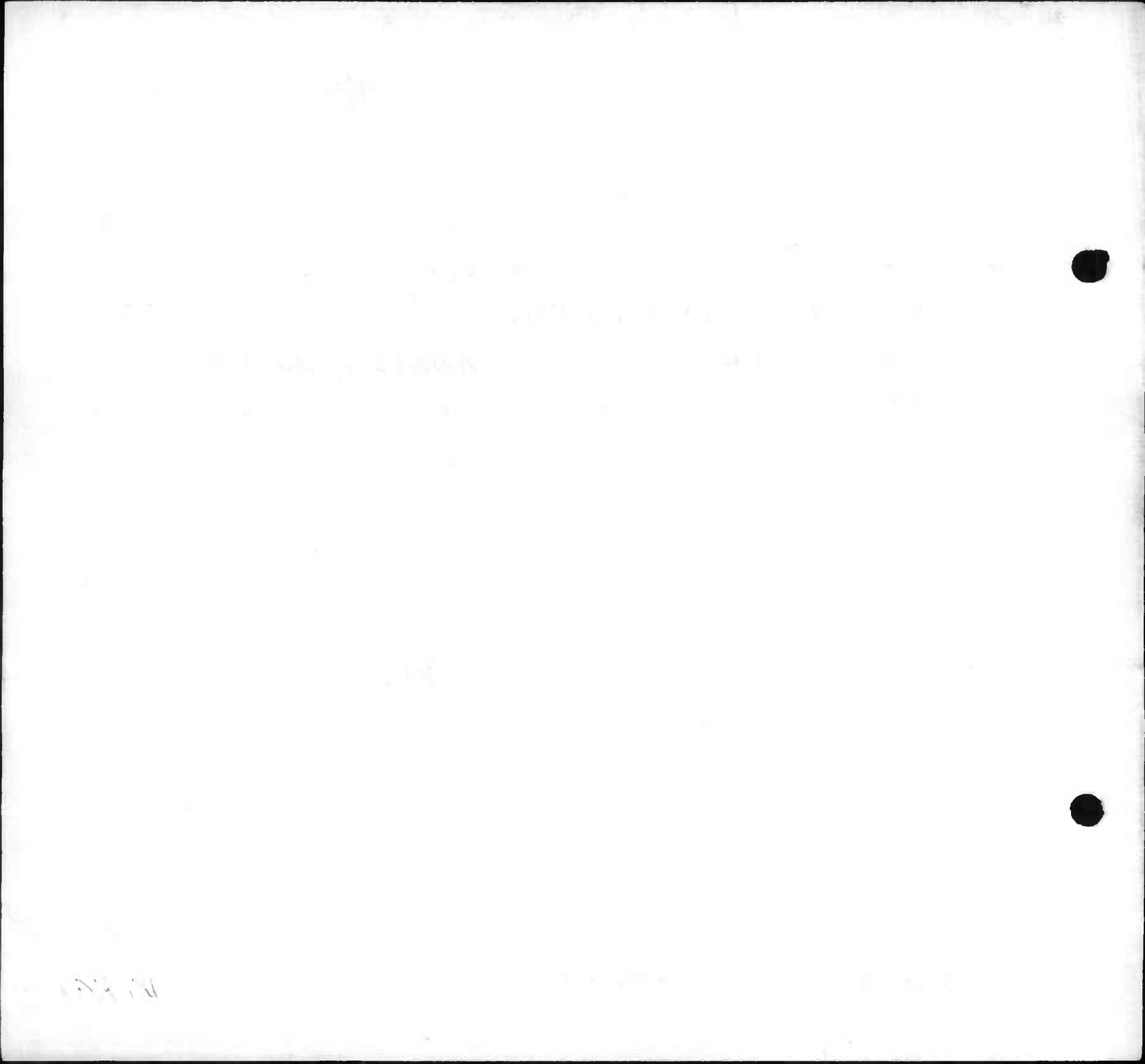
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 6946</u>	
BIRTH NO. <u>A-534</u>		70 <u>6946</u>					
1. NAME OF DECEASED (Type as Print) <u>ANTEL, ELIZABETH</u>				2. DATE AND HOUR OF DEATH July 8, 1970 8:00 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				C. CITY OR TOWN <u>ESSEX</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>3-26-19</u>		9. AGE (In years last birthday) <u>51</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Joseph CAHNEY</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>III yes, give war or dates of service</u>				16. SOCIAL SECURITY NO. <u>175-14-5294</u>		17. INFORMANT <u>BCH: Records Baltimore, Maryland 21224</u>	
18. <u>436.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral Vascular Accident</u> 28 hrs. DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>28 hrs.</u>			
19A. DATE OF OPERATION <u>22</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 (Month) 2 (Day) 3 (Year) 4 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1970</u> to <u>July 8, 1970</u> that (I) (we) last saw the deceased alive on <u>July 8, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE <u>Jeremiah Duwell MD</u>				23B. DATE SIGNED <u>July 8, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>D Jeremiah Duwell M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>7/11/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>GARDENS OF FAITH</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>				25B. NAME OF REGISTRAR <u>Robert E. Jarboe, M.D.</u>		25C. FUNERAL DIRECTOR <u>OVERLEA</u>	
26A. ADDRESS <u>BALTO. CO. MD.</u>				26B. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

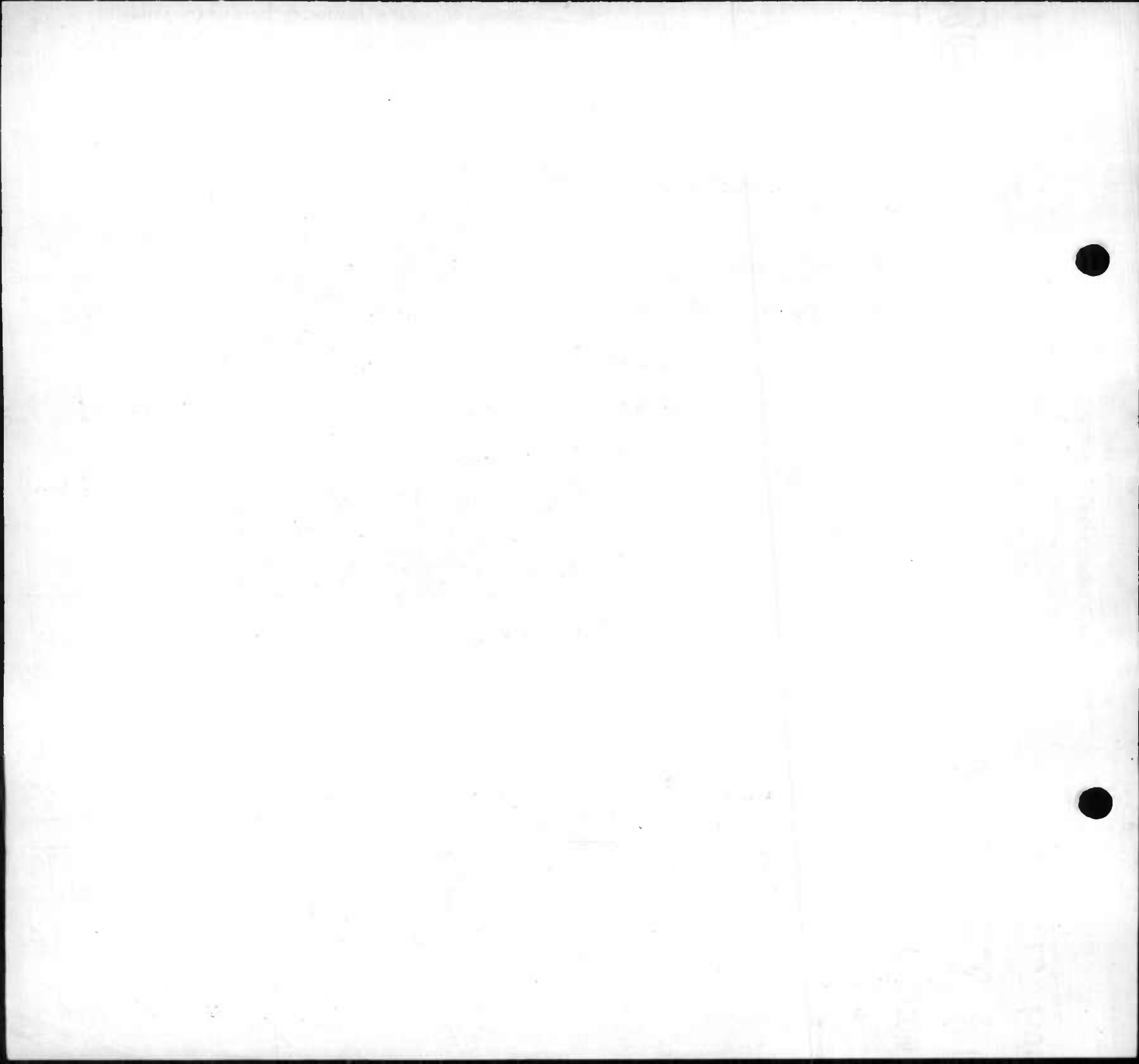
38-76-71		B-640 70 6947		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6947	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Browney E. Brill</u>				2. DATE AND HOUR OF DEATH <u>7/9/70</u> <u>15:30 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> 4940 Eastern Avenue Baltimore, Maryland <u>31</u> 21224				A. STATE <u>Md.</u> B. COUNTY <u>2605</u>			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>524 Quail St.</u> 21224							
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7/30/98</u>	9. AGE (In years last birthday) <u>71</u>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ORDERLY</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>BALTO. CITY HOSP.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>WM BRILL</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE C BRILL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>230-14-4457A</u>		17. INFORMANT <u>BCH; Records Baltimore, Maryland</u> ADDRESS <u>4940 Eastern Avenue</u> 21224	
18. <u>200.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>cardiorespiratory arrest</u> <u>pneumonia - gram negative</u> (B) <u>lymphosarcoma, transitional</u> DUE TO, OR AS A CONSEQUENCE OF: <u>cell carcinoma of kidney</u> (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(this hospital)</u> attended the deceased from <u>6/22</u> 19 <u>70</u> to <u>7/9</u> 19 <u>70</u> that <u>(we)</u> lost saw the deceased alive on <u>7/9</u> 19 <u>70</u> and that <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did not) view the body after death.							
23A. SIGNATURE <u>Loren G. Lipson, MD</u> DEGREE				23B. DATE SIGNED <u>7/9/70</u>		23C. ADDRESS <u>Baltimore City Hospital</u> 21224	
23D. ADDRESS <u>4940 Eastern Avenue Baltimore, Maryland</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24B. DATE <u>7/16/70</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. HEBRON</u>		24D. LOCATION (City, town, or county) (State) <u>WINCHESTER VIRGINIA</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u>		25C. FUNERAL DIRECTOR <u>J. H. Connelly More Essex</u> ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

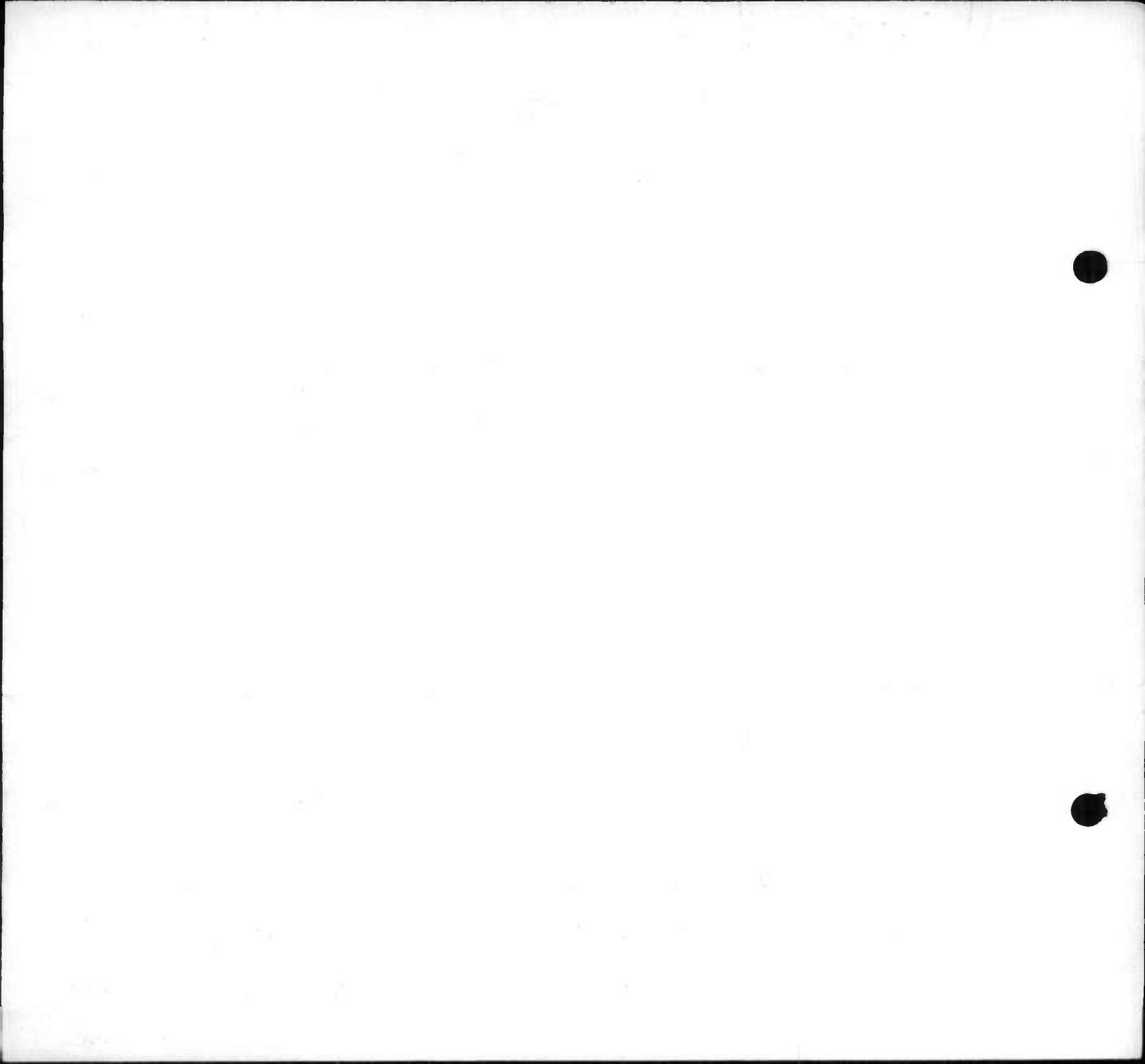
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6948	
W-255 70 6948		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MABEL C. WEISMAN	
2. DATE AND HOUR OF DEATH JULY 8, 1970 7:30 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION 00 4909 CATALPHA ROAD		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 2733		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4909 CATALPHA RD.			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 29, 1891 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.S. PRACTITIONER		10B. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. N. R. CROW		14. MOTHER'S MAIDEN NAME MARGARET A. SMITH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-10-6085	
17. INFORMANT R. A. SNYDER - 2204 N. CHARLES ST.		ADDRESS	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1. Carcinoma Colon & Melodosis + Mils Periton 2. arteriosclerotic heart disease coronary artery disease colorectal cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - 2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from July 15, 1965 to July 8, 1970 , and that (I) (we) last saw the deceased alive on July 15, 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE Donald W. Mintzer		23B. DATE SIGNED 7-9-1970	
23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER		23D. ADDRESS 3009 EVERGREEN AVE. BALTO., MD.	
24A. DATE OF REMOVAL (Specify) CREMATION		24B. DATE 7-9-1970	
24C. NAME OF CEMETERY OR CREMATORY GREEN MOUNT		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. JUL 18 1970		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR St. Bridget's Burial, Randolph, Md.		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

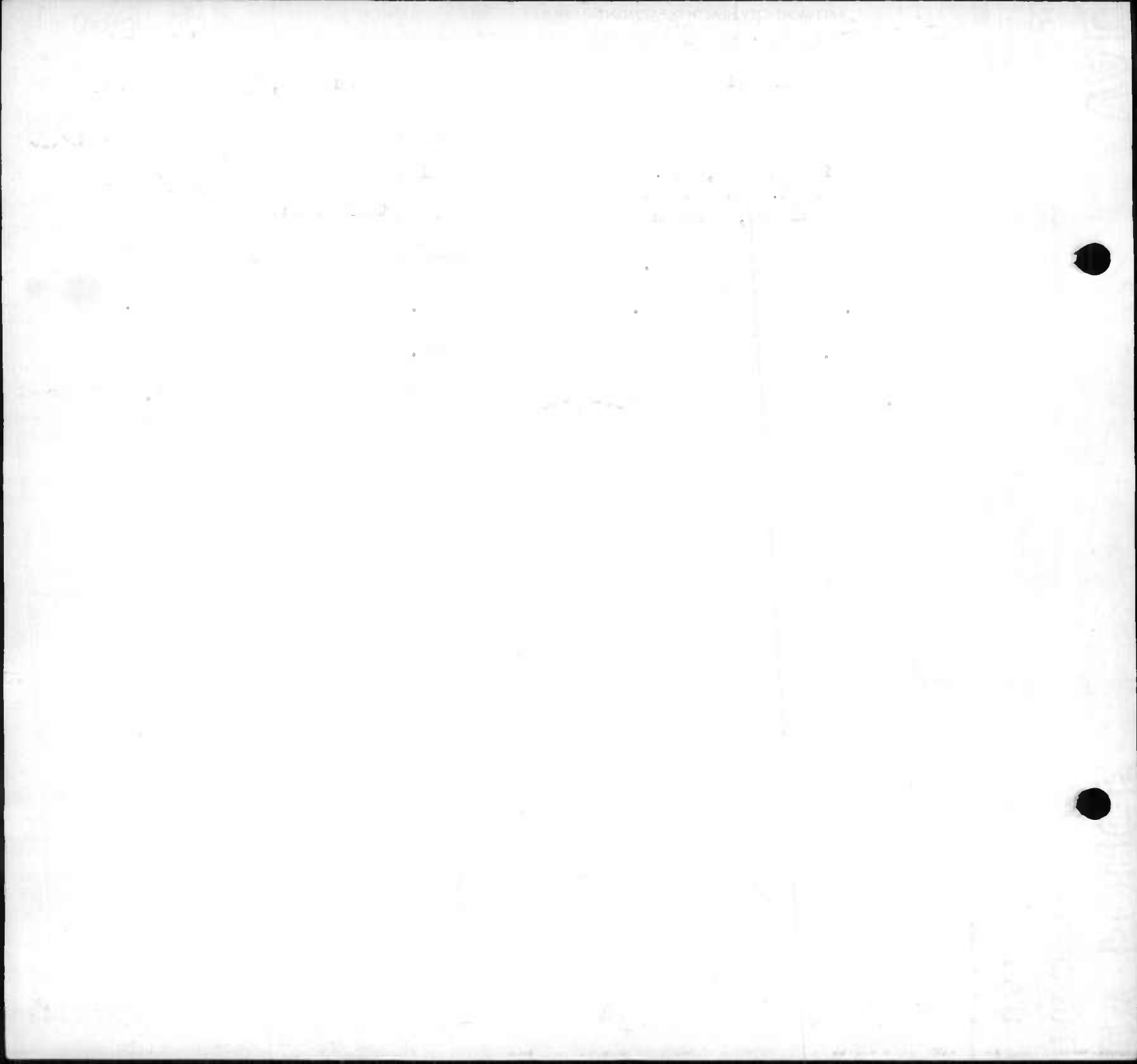
W-300		70 6949		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6949	
BIRTH NO.				2			
1. NAME OF DECEASED (Type or Print) EMMA M. WOOD				2. DATE AND HOUR OF DEATH 7/9/70 6:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital				A. STATE MD.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY 2102			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1218 James St.							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-97	9. AGE (In years last birthday) 72	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Longley				14. MOTHER'S MAIDEN NAME CAVEY Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 7		17. INFORMANT Dr. Melvin E. Veiter		ADDRESS 667 Riverside Drive	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) +10.94 I 153.8				CAUSE OF DEATH Posterior myocardial infarct			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Occ. (5) coronary			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Carcinoma, colon & partial obstruction? thrombosis in popliteal vein days							
19A. DATE OF OPERATION 6-23-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Colon cancer		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6-20 19 70 to 7-9 19 70 that (I) (we) last saw the deceased alive on 7-9 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Narciso A. De Borja MD				23B. DATE SIGNED 7-9-70		23C. PHYSICIAN'S NAME (Type) NARCISO A. DE BORJA, M.D.	
23D. ADDRESS Bon Secours Hosp. Baltimore				23E. DATE REC'D BY HEALTH DEPT. JUL 13 1970		23F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
23G. FUNERAL DIRECTOR John F. Cronan Son Inc.				23H. ADDRESS 2522 St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/13/70		24C. NAME OF CEMETERY OR CREMATORY Western Cem.	
24D. LOCATION Baltimore				24E. STATE MD.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

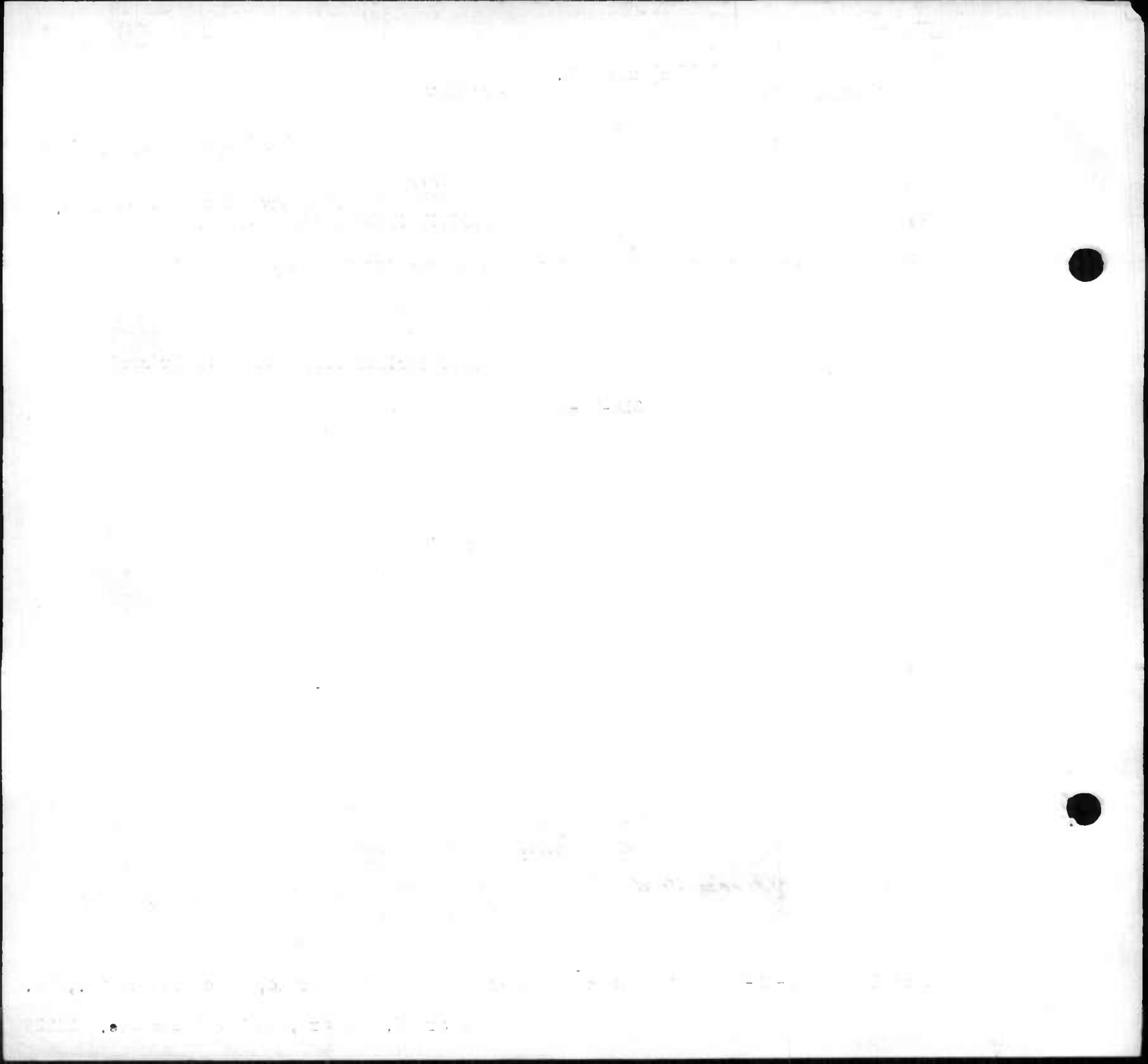
G-632 70 6950 BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 70 6950	
BIRTH NO. 70 6950 M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) John Gritzer			
2. DATE AND HOUR OF DEATH June 24, 1970 9:30 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 203		5. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
6. STREET ADDRESS (If rural, give location) 2003 Eastern Avenue		7. DATE OF BIRTH 1/18/11 9. AGE (In years last birthday) 59			
8. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Unk.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10B. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (State or foreign country) Unk.		12. CITIZEN OF WHAT COUNTRY? Unk.			
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 196-09-6391		17. INFORMANT Midtown Home	
ADDRESS 808 St. Paul Street					
18. 5710 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest		CAUSE OF DEATH (A) DUE TO Cardiac Arrest		INTERVAL BETWEEN ONSET AND DEATH Sudden	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis - Alcohol		(B) DUE TO Arteriosclerosis - Alcohol		?	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Palatal Tumor Pneumonia		100%			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/19 19 70 to 6/24 19 70 , that (I) (we) last saw the deceased alive on 6/24 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 6/24/70	
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM M.D.		23D. ADDRESS 1115 N. Calvert St			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-70		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, MD.					
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR W. W. WEARS, SONS	
ADDRESS NORTH PENN.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6951	
E-256 70 6951 CERTIFICATE OF DEATH					
BIRTH NO. 70 6951		1. NAME OF DECEASED (Type or Print) XXXXXXXXXXXX MARJORIE L. Eismeier		2. DATE AND HOUR OF DEATH THURSDAY JULY 9/70 10³⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL 38			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY XXXXXXXXXX 2632 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5213 Frankford Avenue Apt. B XXXXXXXXXXXXXXXXXXXXXXXXXXXX		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/09	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK.	
13. FATHER'S NAME LLOYD R. GREEN		14. MOTHER'S MAIDEN NAME XXXXXXXXXXXX Ella May Griswold		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-24-10740		17. INFORMANT Maurice M. Ross, M.D., C.M. 22 South Greene St. Baltimore 21201	
18. 146.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE METASTATIC DISEASE and DUE TO, OR AS A CONSEQUENCE OF: (B) INANITION DUE TO, OR AS A CONSEQUENCE OF: (C) CARCINOMA of TONSIL.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). NIL.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS.		
19A. DATE OF OPERATION 4-15-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BIOPSY of CERVICAL AND 13) CERVICAL NODE		20A. AUTOPSY? (Yes or No) NO.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from APRIL 9 19 70 to JULY 9 19 70 that (1) (we) last saw the deceased alive on JULY 9/70 8³⁰ A.M. 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Maurice M. Ross, M.D., C.M.				23B. DATE SIGNED JUL 9, 1970	
23C. PHYSICIAN'S NAME (Type) DR. WINIFRED M. ROSS				23D. ADDRESS 22 SOUTH GREENE ST. BALTIMORE, MARYLAND 21201.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-1970		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Talley, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	
24D. LOCATION (City, town, or county) (State) Glen Burnie, Anne Arundel Co., Md.					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Landers, Day

2. DATE OF DEATH
Known ☐ Month Day Year Hour
Estimated ☐ 6 22 70 8:09 a.m.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home Hospital

3. DATE PRONOUNCED DEAD
Month Day Year Hour
6 22 70 8:09 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Md.

B. COUNTY

301

6. SEX

male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

5.9.1918

10. AGE (in years last birthday)

52

11. If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

9 S. Eden St.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wilburn Day

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Printer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

St. L. Tawen

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, near unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

246-12-9718

18. INFORMANT

ADDRESS

8 no Park 1600 Poplar Grove St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Hypertensive cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐
Deputy Chief Medical ExaminerDATE SIGNED
6-22-70

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

6.24.70

24C. NAME OF CEMETERY or CREMATORY

Mount Auburn

24D. LOCATION (City, town, or county)

Balto City Md

25A. DATE REC'D BY HEALTH DEPT.

JUL 13 1970

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Ludlow & Carroll Balto. Md

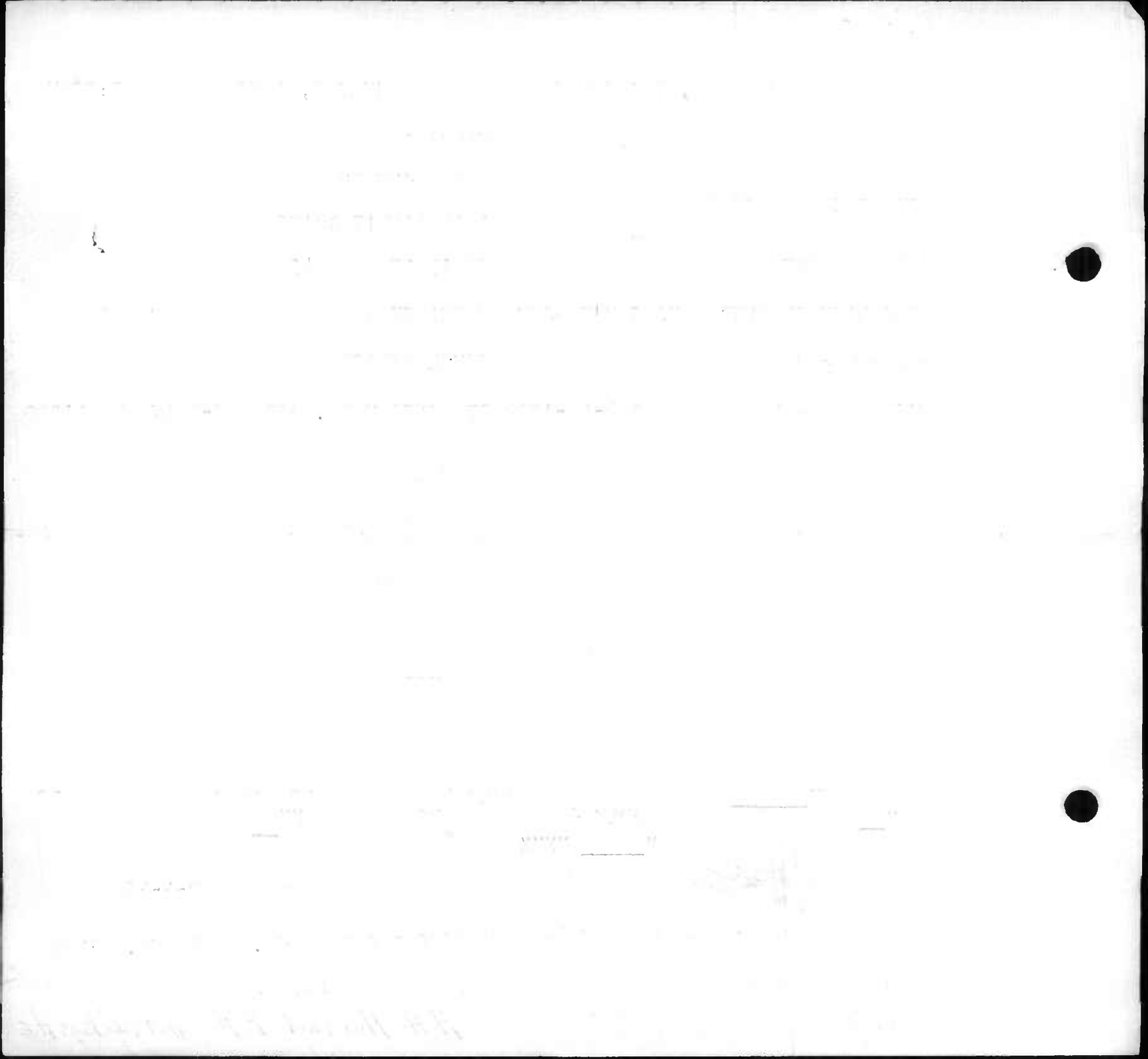
ADDRESS

Handwritten signature or initials, possibly "M. J. Smith".

FUNERAL DIRECTOR: IMPORTANT

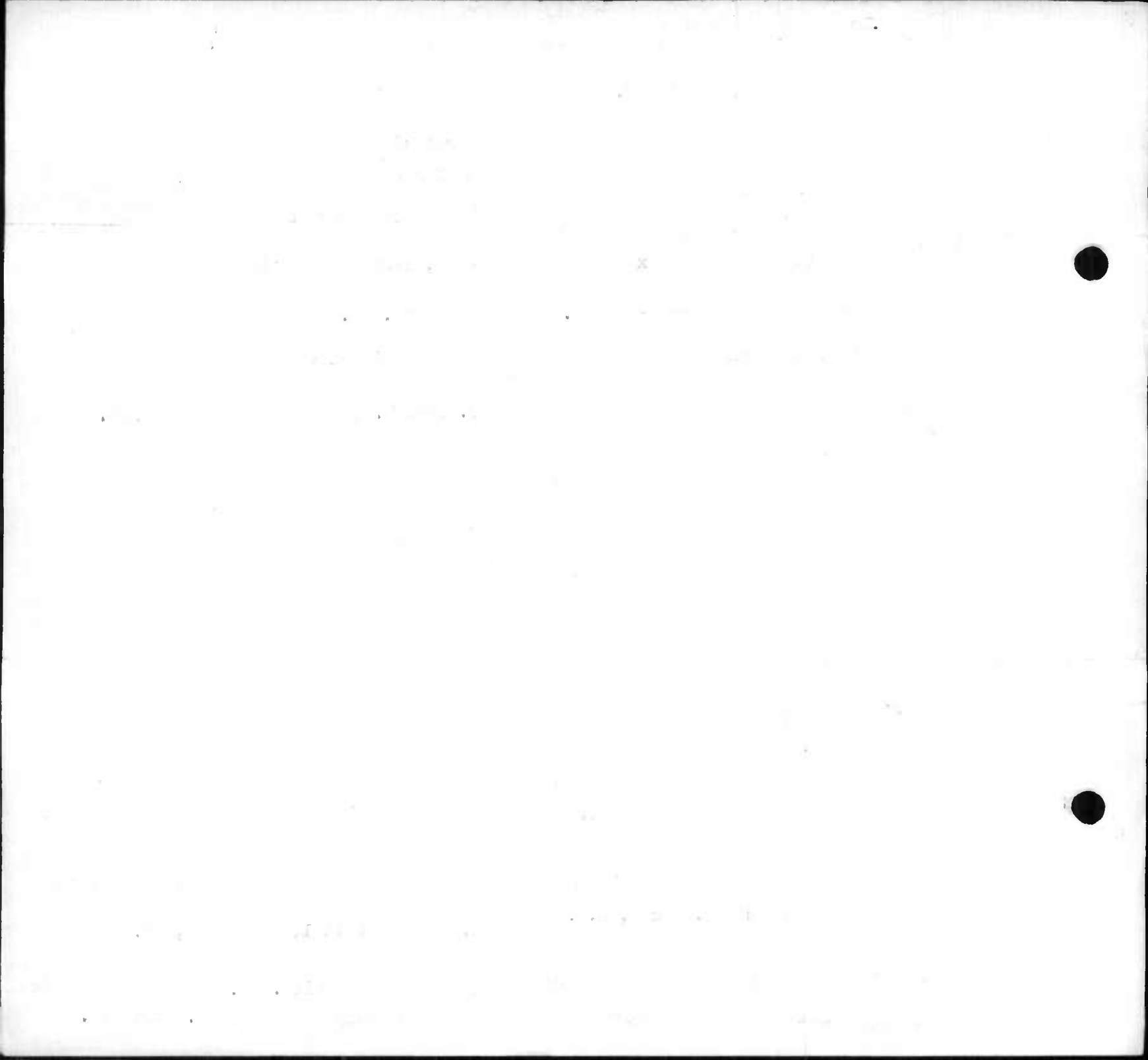
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J-525 70 6953		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
JOHNSON, TED JAMES		JULY 6, 1970 7:00PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
ST AGNES HOSPITAL		VIRGINIA	
5. SEX		6. RACE	
MALE		WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		06 17 27	
9. AGE (In years last birthday)		43	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
PHOTOLITHOGRAPHER		WASHINGTON	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
US GOV'T NAVY		U S A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
TED JOHNSON		ETHEL REPASS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
YES WW 2		224-28-1714	
17. INFORMANT		ADDRESS	
ST AGNES HOSP.		RECORDS-BALTO MD 21229	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE	
DUE TO, OR AS A CONSEQUENCE OF:		AC. M.I.	
ANTECEDENT CAUSES		(B) AC. Coronary occlusion	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:	
		AC. Pul. embolism	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		YES	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. HOW DID INJURY OCCUR?	
21F. INJURY OCCURRED			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from JULY 4 19 70 to JULY 6 19 70 that (M) (we) last saw the deceased alive on JULY 6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
M. AFZAL		7-7-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
M. AFZAL		WILKENS & CATON AVE. BALTO MD 21228	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		7-10-70	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Culpeper National Cemetery		Culpeper, Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
JUL 13 1970		Robert E. Taylor	
25C. FUNERAL DIRECTOR		ADDRESS	
H. H. Hubbard F. H.		4109 Wilkens Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

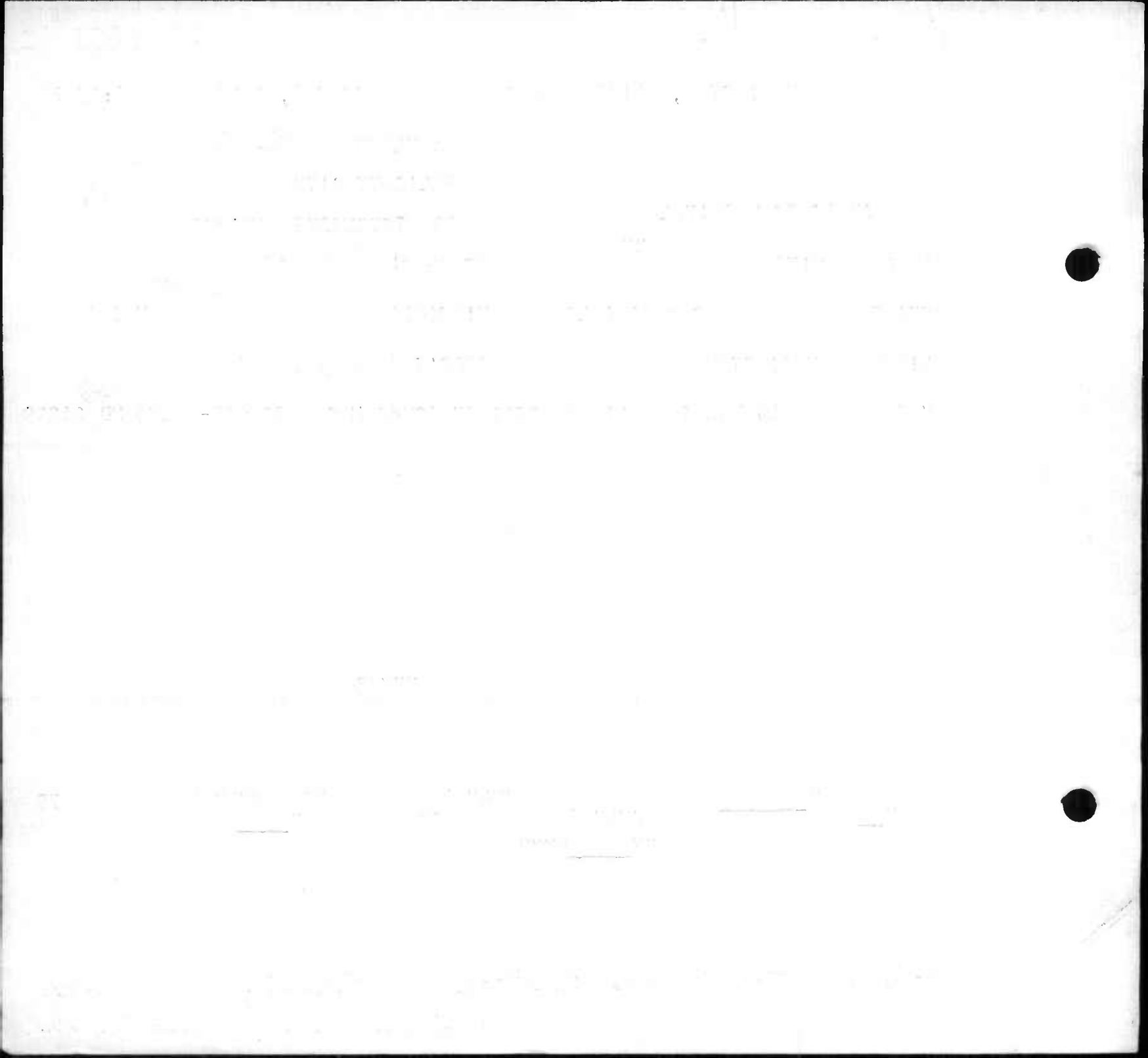
B-652 70 6954		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6954	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BURNS, William J.		July 10, 1970 12:20 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		Maryland		2553	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1912 Maisel Street			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1906	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Ice Cream Co.		11. BIRTHPLACE (State or foreign country) Balto. Md.	
13. FATHER'S NAME Lawrence Burns		14. MOTHER'S MAIDEN NAME Addie Smith		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. John W. Burns 2918 Delaware Ave.	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac arrest.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Heart failure & DUE TO, OR AS A CONSEQUENCE OF:			
		(C) Arteriosclerosis - C.V. Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis J. Macek, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 7-10-70	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS St. Agnes Hospital, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7 13 70		24C. NAME of CEMETERY or CREMATORY Loudon Park	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR John E. Macek, M.D.		25C. FUNERAL DIRECTOR ADDRESS Mc Cully 130 E. Fort Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>70 6955</u>
0-165 BIRTH NO.		70 6955		
1. NAME OF DECEASED (Type or Print)		OVERINGTON, OLIVER WARREN		2. DATE AND HOUR OF DEATH JULY 6, 1970 6:15 P M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Balto. 53-00		
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		C. CITY OR TOWN ELLICOTT CITY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER 32 WESTCHESTER AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05 02 94	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY C R DANIELS		11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME OLIVER W OVERINGTON		14. MOTHER'S MAIDEN NAME BESSIE (ALLEN)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR 1		16. SOCIAL SECURITY NO. 218 09 7517		
		17. INFORMANT ST AGNES HOSP RECORDS-BALTO MD 21229		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 436.9 I CAUSE OF DEATH (A) IMMEDIATE CAUSE Extensive pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) CVA. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (X) (this hospital) attended the deceased from JULY 4 19 70 to JULY 6 19 70 that (X) (we) last saw the deceased alive on JULY 6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) (X) view the body after death.				
23A. SIGNATURE Ching-Hui Tsai, M.D.		23B. DATE SIGNED 7/6/70		23C. PHYSICIAN'S NAME (Type) Ching-Hui Tsai, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-9-70		24C. NAME OF CEMETERY OR CREMATORY Good Shepherd
24D. LOCATION Ellicott City, Md.		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Higinbotham-Slack		
		ADDRESS Ellicott City, Md.		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT BRADSHAW		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> July 8, 1970	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 400 N. Kenwood Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour July 8, 1970 4:10 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov 2 1914		10. AGE (in years last birthday) 55	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ALBERT S. Bradshaw		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 602	
15. MOTHER'S MAIDEN NAME ADA BERTON		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 243-01-4459		18. INFORMANT ANNIE BASS SILVER SPRING MD.	
19. 532.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive intestinal hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II Cirrhosis and Arteriosclerotic cardiovascular disease		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED July 9, 1970			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-70	
24C. NAME OF CEMETERY or CREMATORY PINE VIEW CEM		24D. LOCATION (City, town, or county) (State) Rocky Mount N.C.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Higginbottom-Slack		25D. ADDRESS Ellicott City MD 21043	

JANUARY 1, 1918

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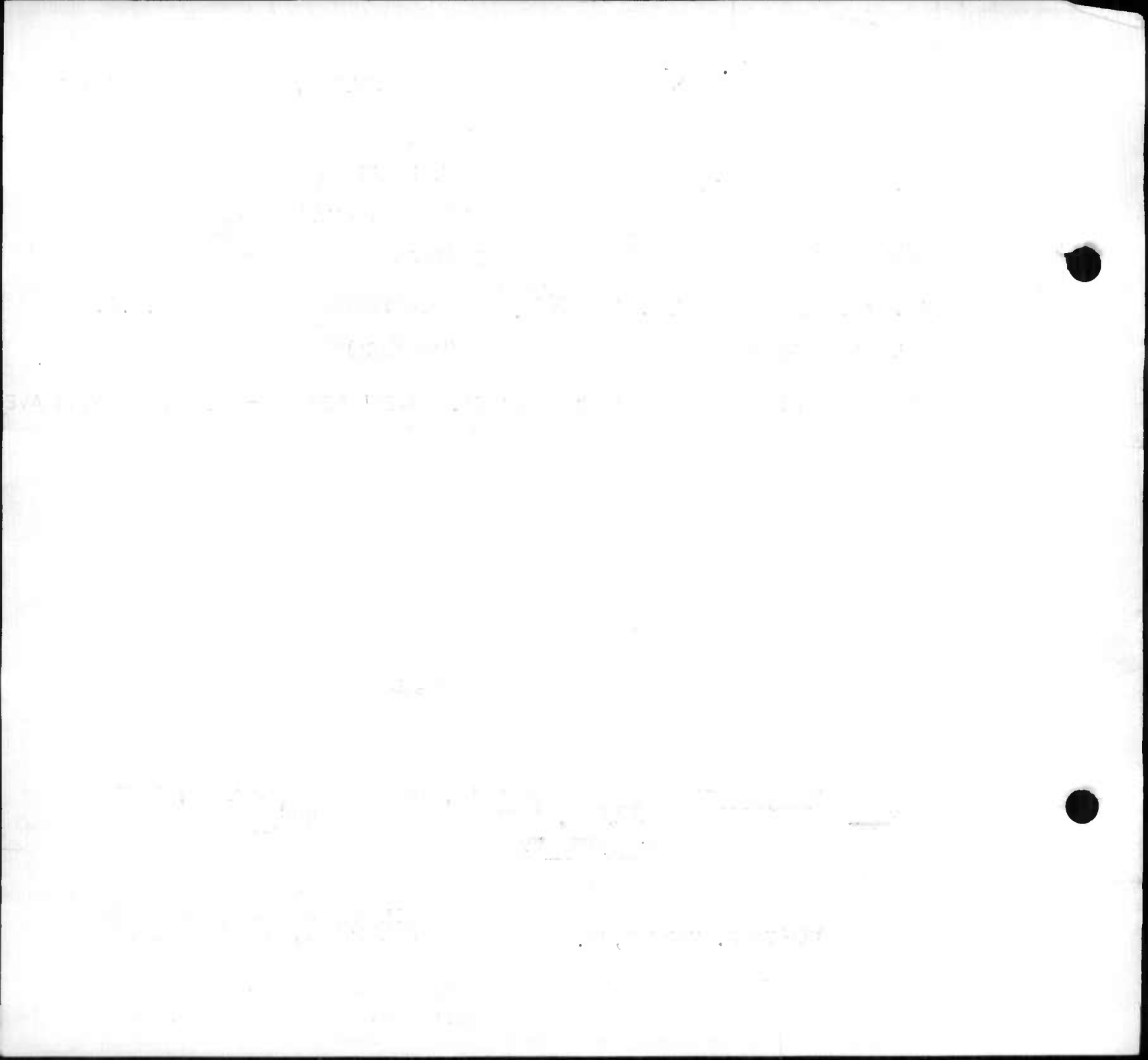
JANUARY 1, 1918

JANUARY 1, 1918

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

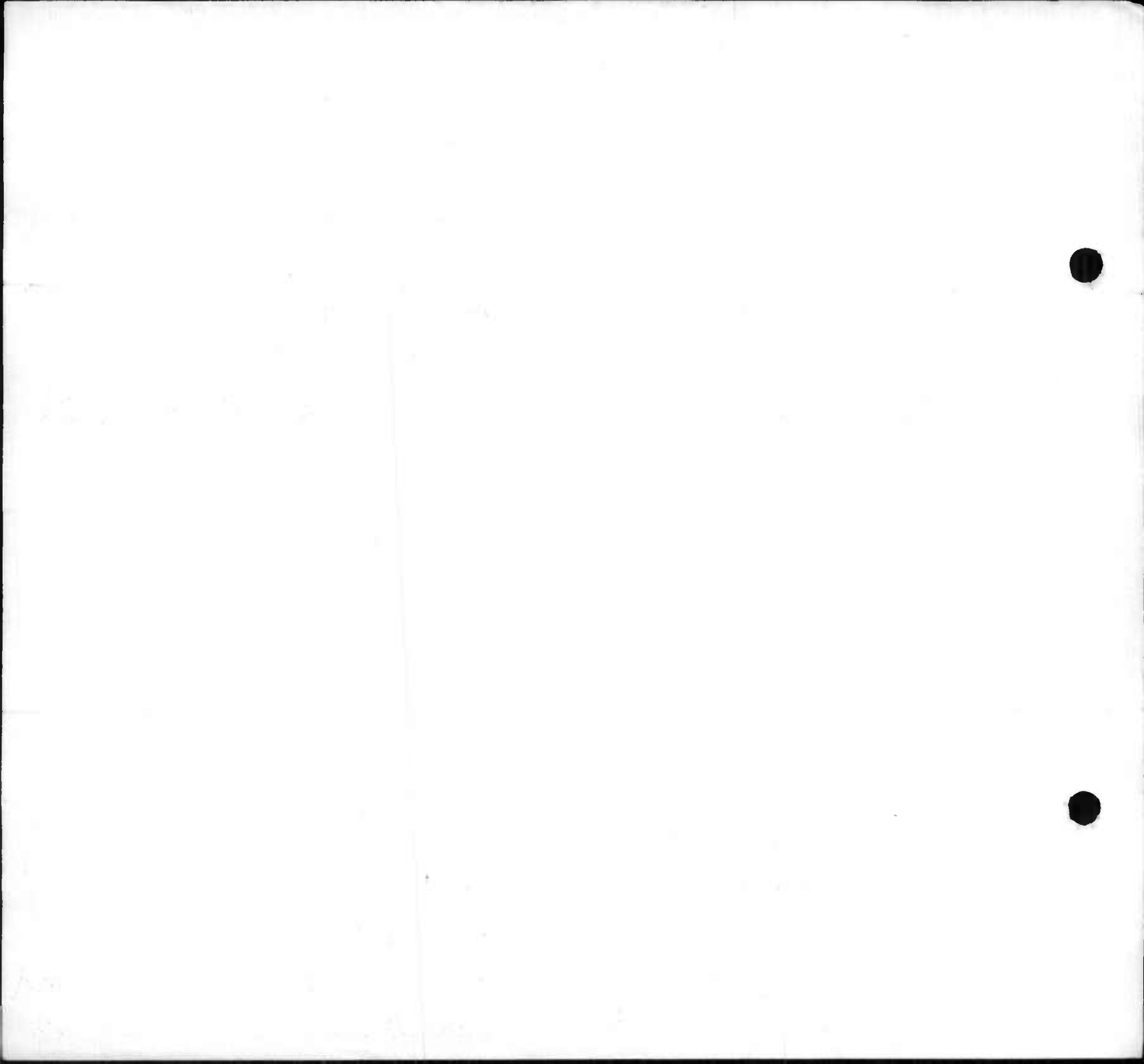
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6957	
BIRTH NO. B-655 70 6957				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ARTHUR FRED BROMMUND			2. DATE AND HOUR OF DEATH JULY 8, 1970 12:20P		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL 40			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2006 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 17 NORTH HILTON STREET		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/96	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. POLICEMAN		10B. KIND OF BUSINESS OR INDUSTRY POLICE BATO. CITY DEPT.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ALBERT BROMMUND			14. MOTHER'S MAIDEN NAME (UNKNOWN)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 215 28 4601		17. INFORMANT ADDRESS ST. AGNES' RECORDS-WILKENS & CATON AVE	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)			(A) IMMEDIATE CAUSE terminal Pneumonia DUE TO, OR AS A CONSEQUENCE OF: PYELONEPHRITIS EMPHYSEMA (B) DUE TO, OR AS A CONSEQUENCE OF: LYMPHOMA (C)		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 19, 1970 to JULY 8, 1970 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 8, 1970 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) <input checked="" type="checkbox"/> (did) view the body after death.					
23A. SIGNATURE Donato A. Vargas Jr			23B. DATE SIGNED 07-08-70		
23C. PHYSICIAN'S NAME (Type) DONATO A. VARGAS, JR.			23D. ADDRESS WILKENS AND CATON AVENUES BALTIMORE, MARYLAND 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 7/11/70	24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS Loring Byers-8728 Liberty Road 21133	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6958	
CERTIFICATE OF DEATH				REG. NO. 70 6958	
BIRTH NO. 8-120		70 6958			
1. NAME OF DECEASED (Type or Print) SAVAGE, GERALDINE			2. DATE AND HOUR OF DEATH 7/9/70 2:30 am		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1401		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 301 St. Paul Pl. MD 21202			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1203 John St. Balto. MD 21218					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-16-08	9. AGE (in years last birthday) 61	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Welsh		14. MOTHER'S MAIDEN NAME Mary Beekensbaugh	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-07-5714		17. INFORMANT Daughter 2749 Mathews St	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 410.9 I Massive Pulmonary Embolism Myocardial infarction II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 6/23 1970 to 7/9 1970 that (I) (we) last saw the deceased alive on 2:30 am 7/9 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Pratima Bose M.D.		23B. DATE SIGNED 7/9/70		23C. PHYSICIAN'S NAME (Type) PRATIMA BOSE MD	
23D. ADDRESS Mercy Hospital MD 21202		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 7/13/70		24C. NAME OF CEMETERY OR CREMATORY Sacred Heart		24D. LOCATION (City, town, or county) Balto (State) Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970 Robert E. Taylor, M.D.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS					



57-19-09

db

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Allison Viquesney

2. DATE AND HOUR OF DEATH

7/8/70 5:55pm

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1940 Eastern Avenue
Baltimore, Maryland 21224
Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland, B. COUNTY Baltimore

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2716 St. Paul St. 21218 007

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-11-04

9. AGE (In years)

lost birthday 65

10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cab Driver

10B. KIND OF BUSINESS OR INDUSTRY

Sun Cab Co.

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Viquesney

14. MOTHER'S MAIDEN NAME

Anna (Unknown)

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

235-34-2299

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH-Records- Baltimore, Maryland 21224

18.

162.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma Rt Lung

8 MONTHS

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

None

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7/8/70 19 to 7/8/70 19 that (I) (we) last saw the deceased alive on 7/8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Henry Herrera M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

7/8/70

23C. PHYSICIAN'S NAME (Type)

Henry Herrera MD.

23D. ADDRESS

BCH- 4940 Eastern Avenue
Baltimore, Maryland 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-12-1970

24C. NAME OF CEMETERY OR CREMATORY

Fraternal Cemetery

24D. LOCATION

Barbour County, Belington, W. Va.

25A. DATE REC'D BY HEALTH DEPT.

JUL 13 1970

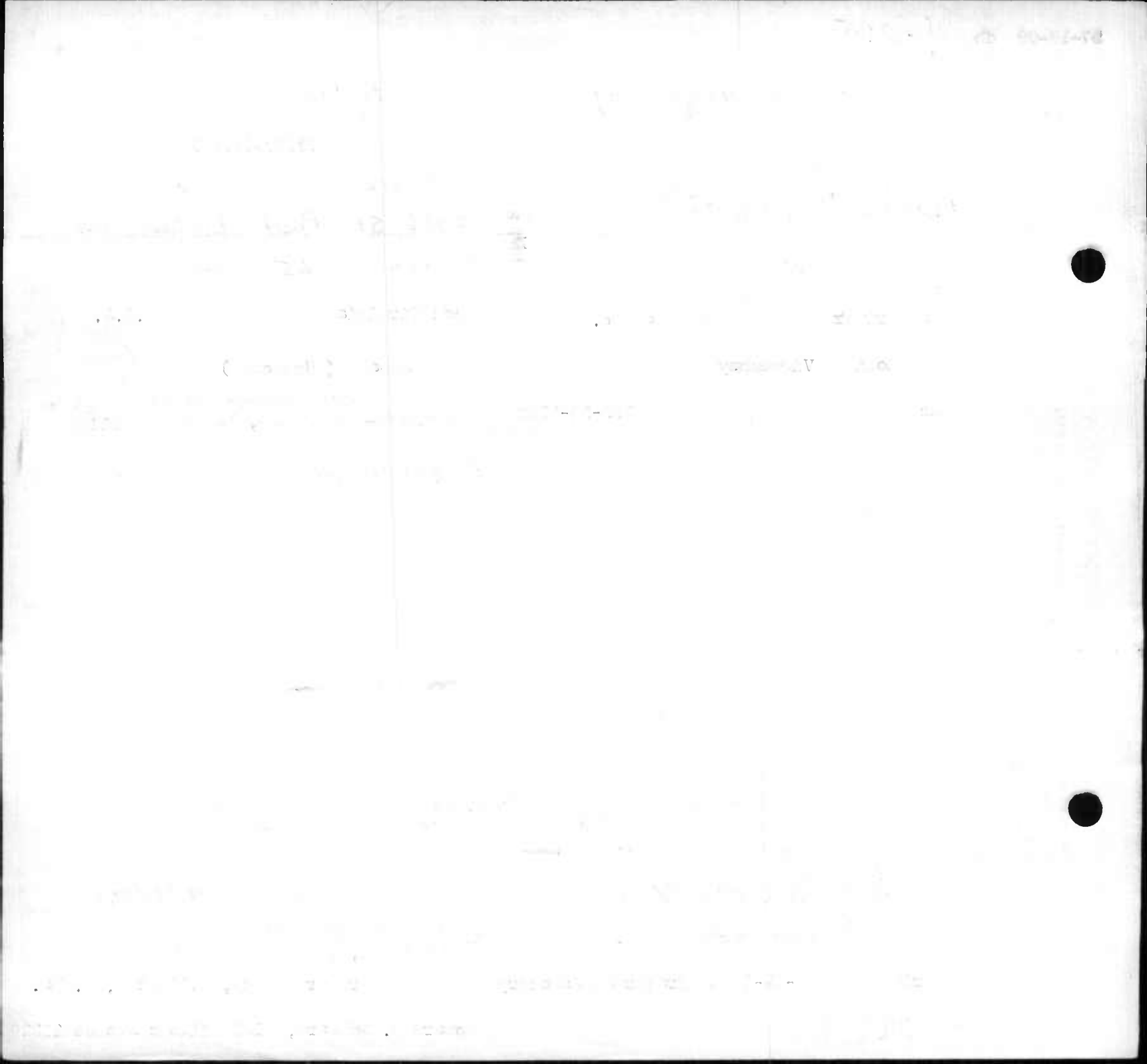
25B. NAME OF REGISTRAR

Robert E. Taylor, MD.

25C. FUNERAL DIRECTOR

Howard H. Hubbard, 4107 Wilkens Avenue 21229

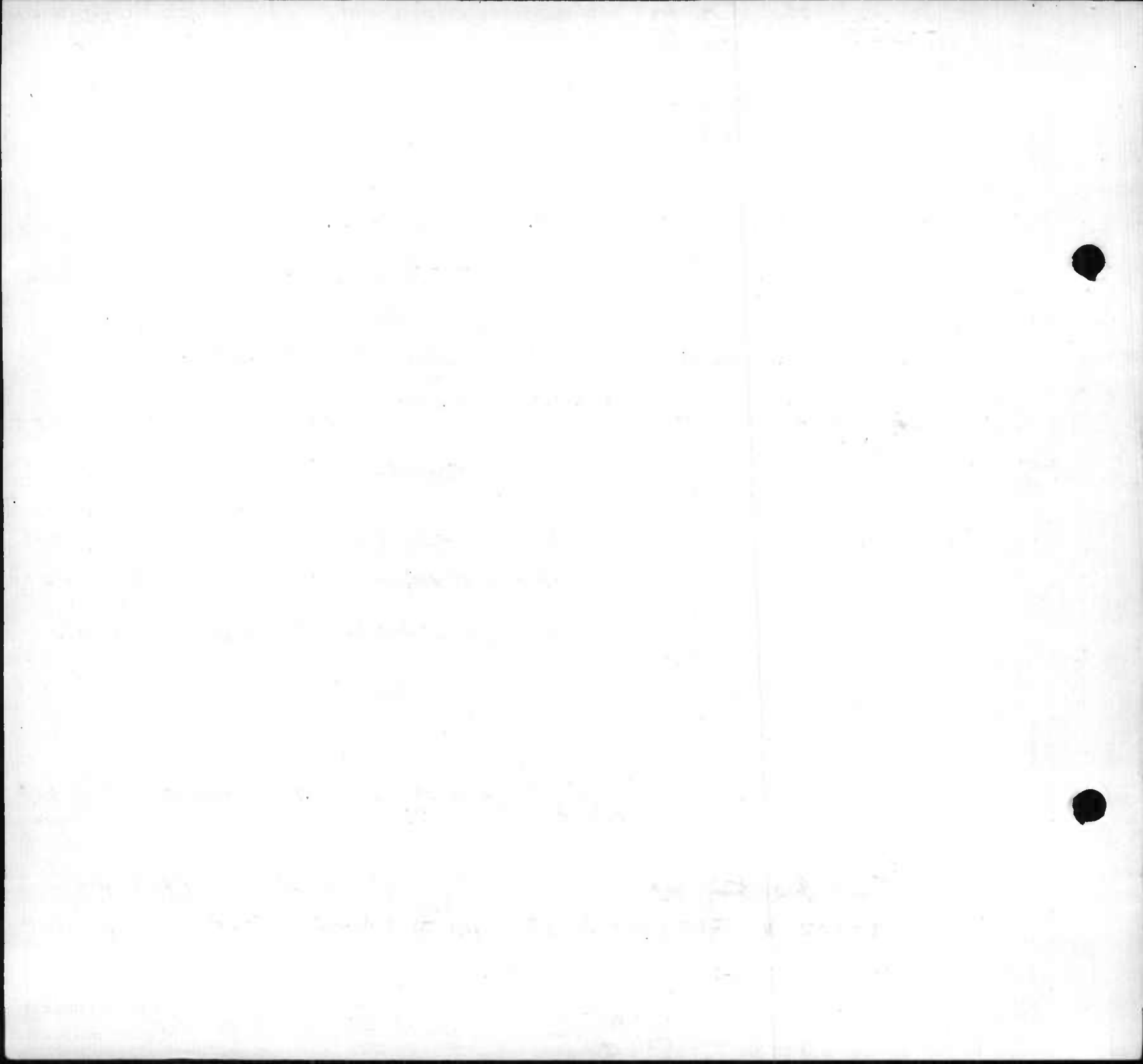
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6960	
BIRTH NO. H-553		70 6960		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) HAMMOND, Oliver			2. DATE AND HOUR OF DEATH July 8, 1970 7:20 9.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Bolton Hill Nursing & Convalescent Ctr.			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1701 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 607 Penna. Avenue 21201		
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8-13-19	
13. FATHER'S NAME Unknown Daniel Hammond		14. MOTHER'S MAIDEN NAME Unknown Elizabeth Merritta		9. AGE (In years last birthday) 50	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 360-09-7304		17. INFORMANT records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration (B) Wernicke's Syndrome (C) Chronic Alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes Several Years Thirty Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Usmary Tract Infection, Resolving		Two Weeks	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 23 1970 to July 8 1970 , that (I) (we) last saw the deceased alive on July 8 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter H. Rheinstein, MD				23B. DATE SIGNED July 8, 1970	
23C. PHYSICIAN'S NAME (Type) PETER H. RHEINSTEIN, MD				23D. ADDRESS 1111 Park Avenue, Baltimore, Md 21201	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-70		24C. NAME OF CEMETERY OR CREMATORY Baltimore, National	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR Walter Dabrowski	
ADDRESS 1005 Dundalk					



CERTIFICATE OF DEATH

REG. NO. 70 6961

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

POWERS, BENJAMIN E

2. DATE AND HOUR OF DEATH

7/8/70 7 AM.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3 Baltimore City Hospital

D-1-E
4940 Eastern Avenue, Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

2636

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1202 Wohler Way

21224

5. SEX

Male

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

1-1-98

9. AGE (In years
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Power

14. MOTHER'S MAIDEN NAME

Martha ?

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL
SECURITY NO.

26-10-161A

17. INFORMANT

Mrs. Martha Power

ADDRESS

2208 N. Paterson

Records: BCH-4940 Eastern Avenue 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 mins

(B) DUE TO, OR AS A CONSEQUENCE OF:

Rnt coall myocardial infarction

15 mos

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Squamous cell CA of lung

11 mos

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/16 1970 to 7/8 1970,
that (I) (we) last saw the deceased alive on 7/8 1970 and that (my) (our) applan death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael W. Posen, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

7/8/70

23C. PHYSICIAN'S
NAME (Type)

Michael W. POZEN, M.D.

23D. ADDRESS

Baltimore City Hosp 4940 Eastern
Baltimore, Md Avenue
2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-10-70

24C. NAME OF CEMETERY or CREMATORY

Mt Carmel Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JUL 13 1970

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

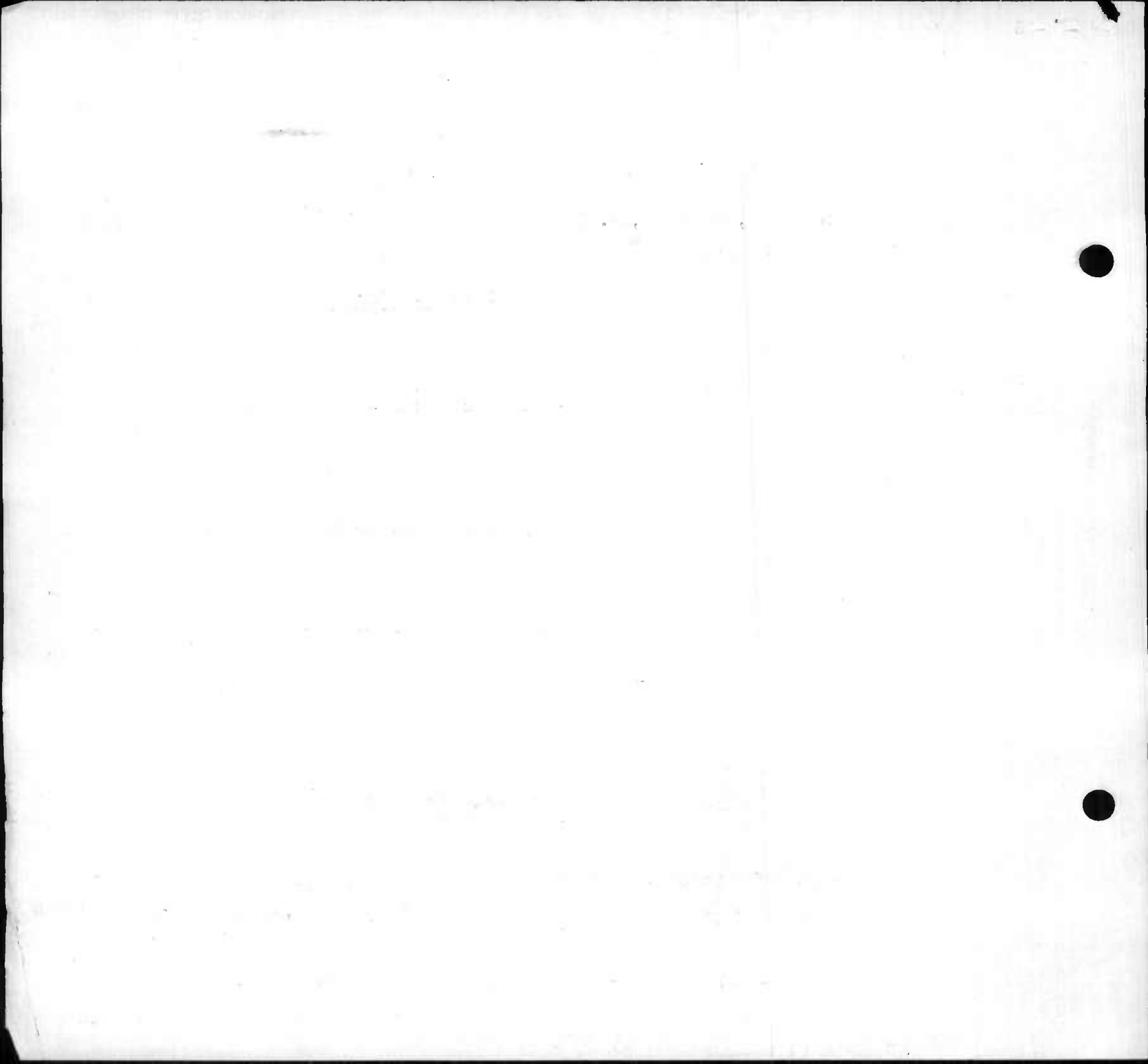
25C. FUNERAL DIRECTOR

WALTER DABROWSKI 1005 DUNDALK AVENUE

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

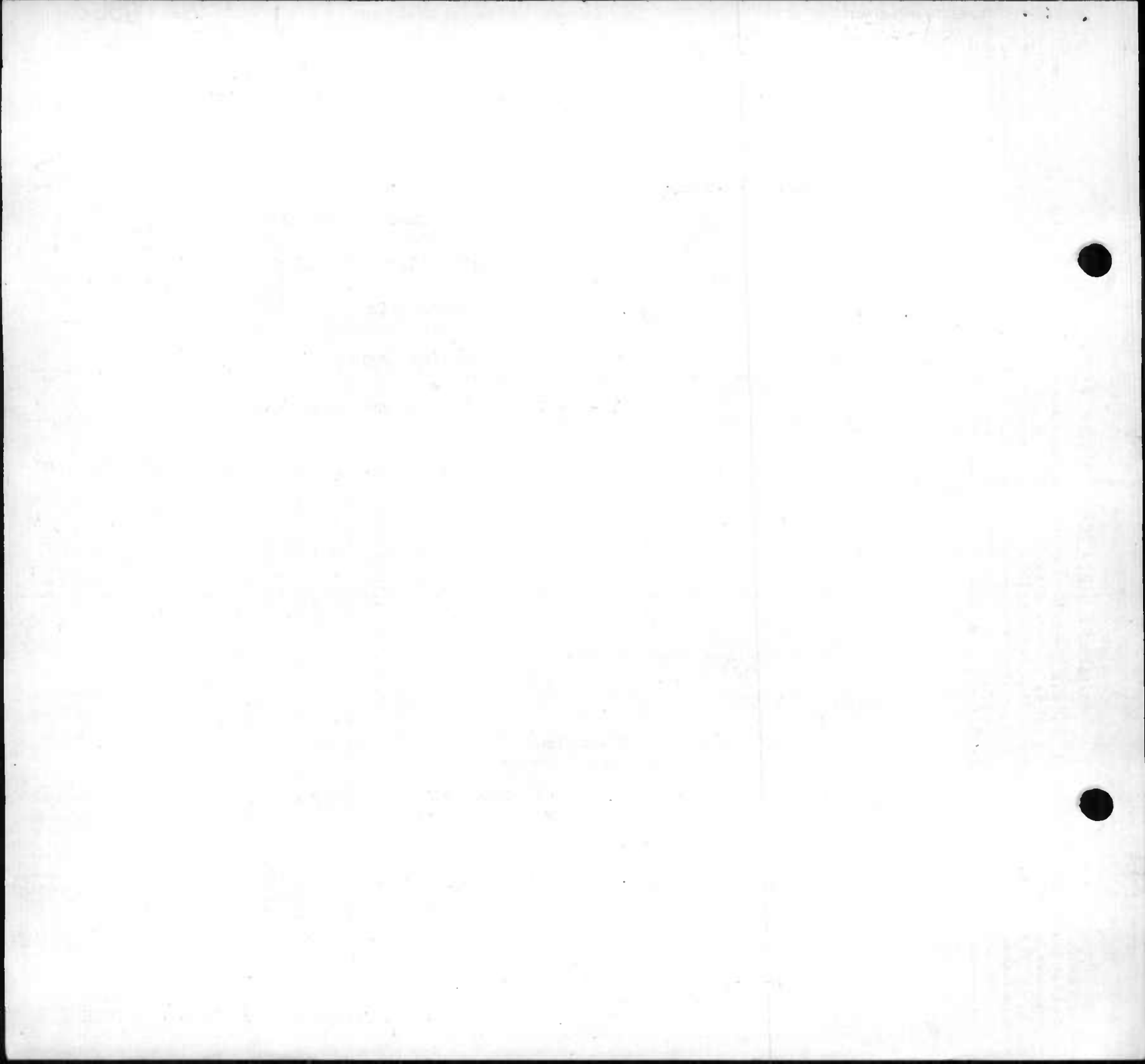
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

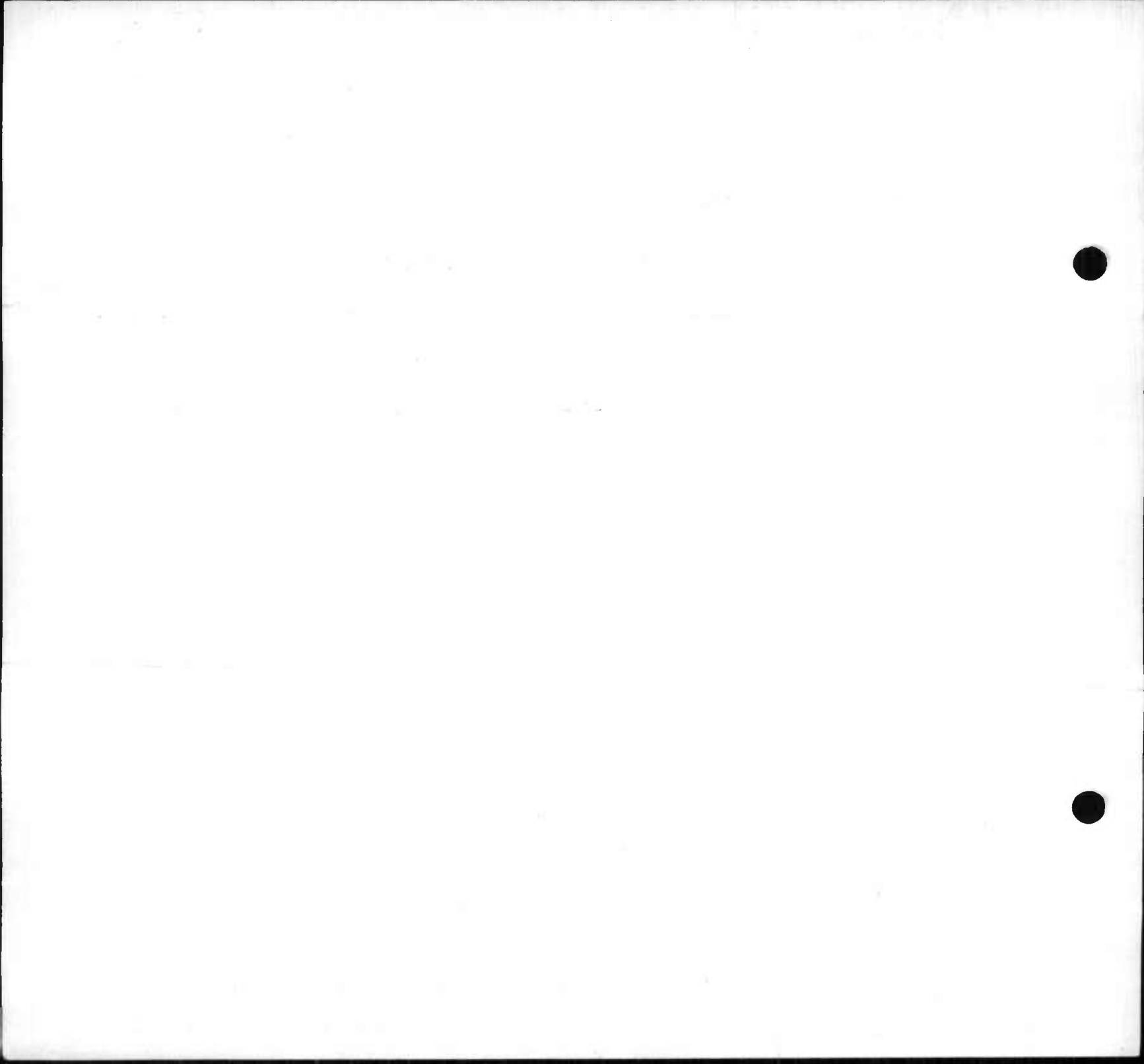
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6962		70 6962		
J-652				70 6962		70 6962		
BIRTH NO.				REG. NO.				
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				
Pauline Joranko				July 8 1970 M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY		
00 II03 Dundalk Avenue				Maryland		2646		
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER				
				II03 Dundalk Avenue				
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours	
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 2 1900	69				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Housewife			home		Monesson Pa			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
Michael Kost				Pauline Wagner				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			
no			214-24-0787		Mike Joranko II03 Dundalk Avenue			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				6. month				
(This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
				Carcinoma Pancreas				
II. ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		Carcinoma Pancreas		No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						
22. I certify that (I) (this hospital) attended the deceased from May 23 1970 to July 8 1970, that (I) (we) last saw the deceased alive on June 17 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		
John W. Ashworth MD						July 9-1970		
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS				
John W. Ashworth MD				1129 17th Ave SE, Balt. Md 21202				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		
Burial		7-II-70		St Stanislaus Cemetery		Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS		
Jul 13 1970		Robert E. Barber		WALTER DABROWSKI		1005 DUNDALK AVENUE		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

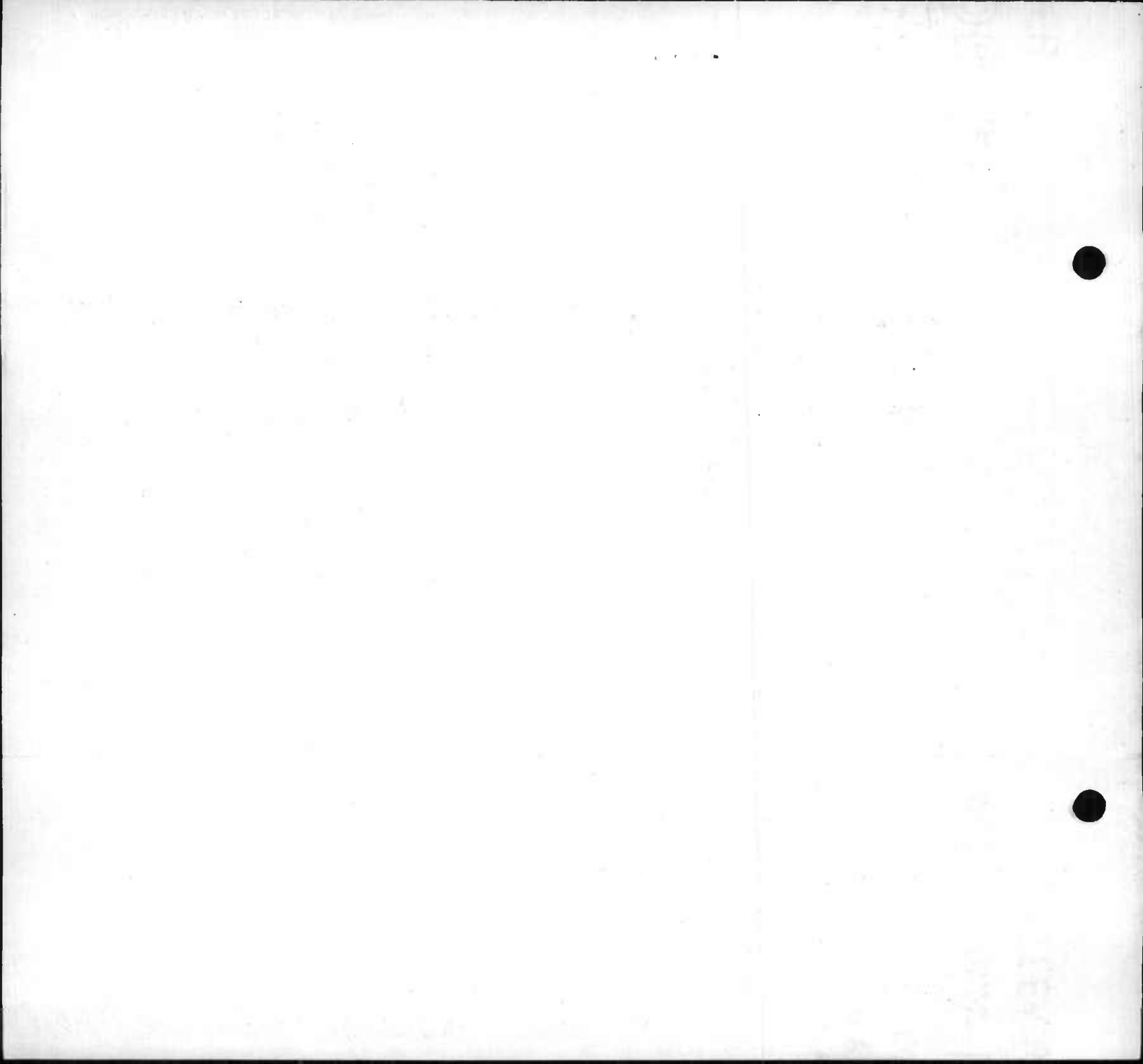
BALTIMORE CITY HEALTH DEPARTMENT				X		70 6963	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lydia Marie Delcher				July 9, 1970		8.15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
House In The Pines Belvedere 2525 W. Belvedere Avenue 21215				Maryland Baltimore 5300			
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female				Caucasian		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife				Home		Sept. 19, 1895	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph F. Whiteley				Anna E. (nee Dwyer)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				220-24-8523		Howard C. Delcher 8 Wendslow Road 21093	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Rheumatic Heart Disease			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Coronary Artery Disease			
				(C) Chronic Nephritis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
None						No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from June 14 19 60 to July 9 19 70 that (I) (we) last saw the deceased alive on July 8 19 70 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Earl L. Chambers M.D.				7/10/70			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Earl Chambers				100 West Cold Spring Lane 21210			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial				July 11, '70		Lorraine Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 13 1970				Robert E. Farber, M.D.		Loring Byers 8728 Liberty Road 21133	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

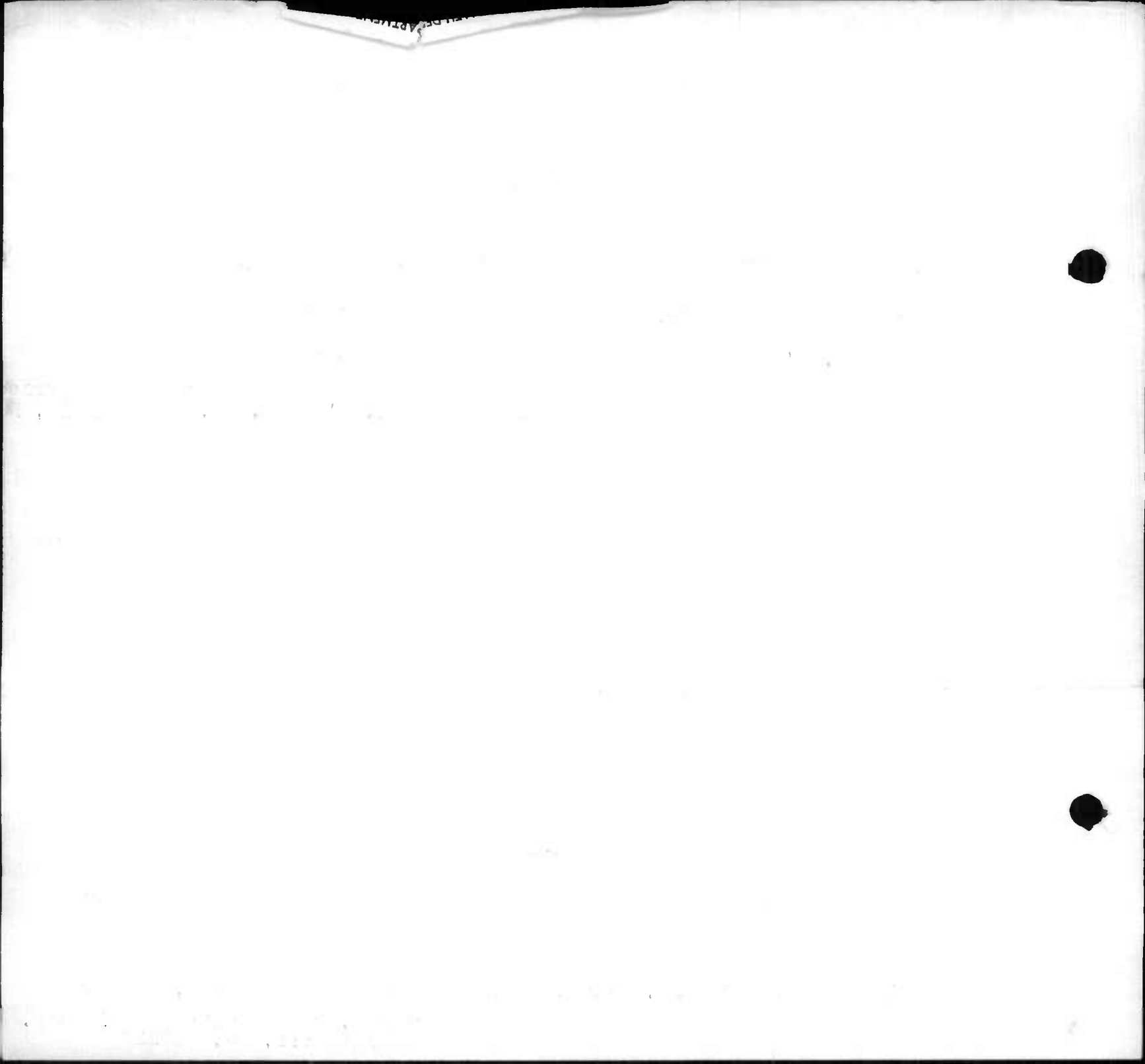
Baltimore City Health Department				70 6964		70 6964	
S-552				70 6964		70 6964	
BIRTH NO.				70 6964		70 6964	
1. NAME OF DECEASED (Type or Print) <i>Schmansky Edward</i>				2. DATE AND HOUR OF DEATH <i>7/9/70 2:50 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>md.</i>		B. COUNTY <i>A.A.C.</i>	
<i>South Baltimore General Hospital,</i>		<i>3001, S. Hanover St, Balto, Md.</i>		C. CITY OR TOWN <i>HORMONS</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Male</i>		6. RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/24/1904</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>66</i>		11. BIRTHPLACE (State or foreign country)	
<i>Watchman (ret)</i>		<i>P.P. Rail Road</i>		<i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Anton Schmansky</i>				14. MOTHER'S MAIDEN NAME <i>Anna Kusyk</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 1923-1927</i>				16. SOCIAL SECURITY NO. <i>A.712-07-6689</i>		17. INFORMANT <i>Mrs. Anna D. Schmansky (Wife)</i>	
18. CAUSE OF DEATH				ADDRESS			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cardiogenic shock.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>acute m. I (Diaphragmatic)</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>A.S.C.V.D. & Coronary artery disease</i> (C) <i>...</i>							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>...</i>		<i>...</i>		<i>...</i>		<i>...</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<i>...</i>		<i>...</i>		<i>...</i>			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
<i>...</i>		<i>...</i>		<i>...</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Baranawala</i>						23B. DATE SIGNED <i>7/9/1970</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. NANAVALI</i>						23D. ADDRESS <i>...</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>11 July 1970</i>		<i>Elm Grove Memorial Pk.</i>		<i>Elm Grove, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 13 1970</i>		25B. NAME OF REGISTRAR <i>...</i>		25C. FUNERAL DIRECTOR <i>R.D. Singleton</i>		ADDRESS <i>Elm Grove, Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

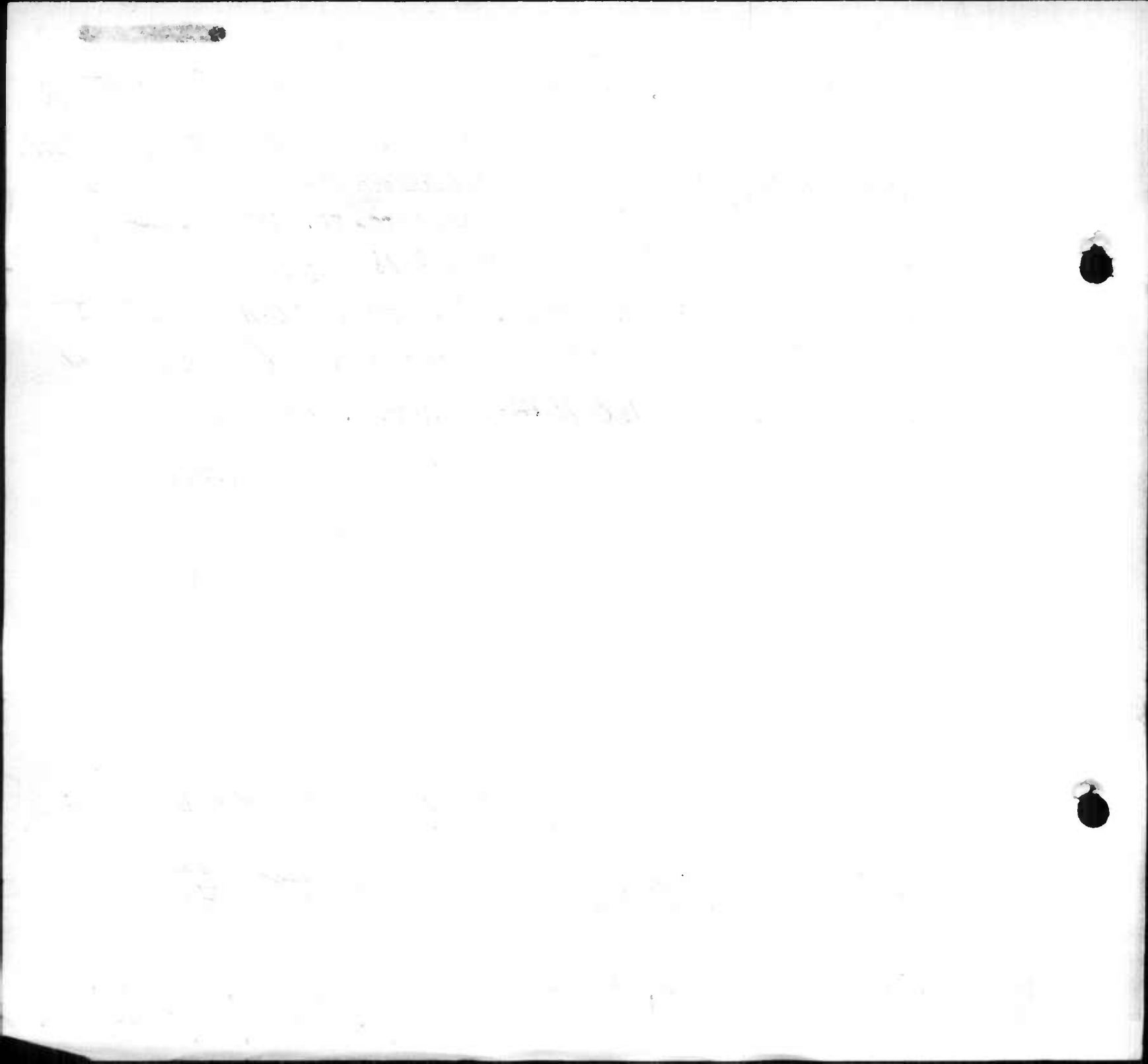
BALTIMORE CITY HEALTH DEPARTMENT				70 6965		REG. NO. 70 6965	
BIRTH NO. 0-160				70 6965		70 6965	
1. NAME OF DECEASED (Type or Print) HARRY A. O'BERRY, SR.				2. DATE AND HOUR OF DEATH 7/6/70 10:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2544 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3823 8th St.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/30/03	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Ship Yard		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward W. O'Berry				14. MOTHER'S MAIDEN NAME Emma Margaret Martin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 09 6628		17. INFORMANT 939 Princeton Terrace Harry A. O'Berry, Jr. Glen Burnie, Md.			
18. 4/10/91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION 6 hrs ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. LEAKING ABDOMINAL AORTA GRAFT 24 hrs				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 7/6/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED LEAKING ABDOMINAL GRAFT		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from 7/5 19 70 to 7/6 19 70 that the (we) last saw the deceased alive on 7/6 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jane S. Mahaffey M.D.				23B. DATE SIGNED 7/6/70		23C. PHYSICIAN'S NAME (Type) JANE E. MAHAFFEY	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 7/9/70		24C. NAME OF CEMETERY or CREMATORY St. Georges Catholic Church Valley Lee, Maryland	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.				25A. DATE RECD BY HEALTH DEPT. JUL 13 1970			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR George J. Gonce 4001 Ritchie Hgy. Baltimore, Md. 21225			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

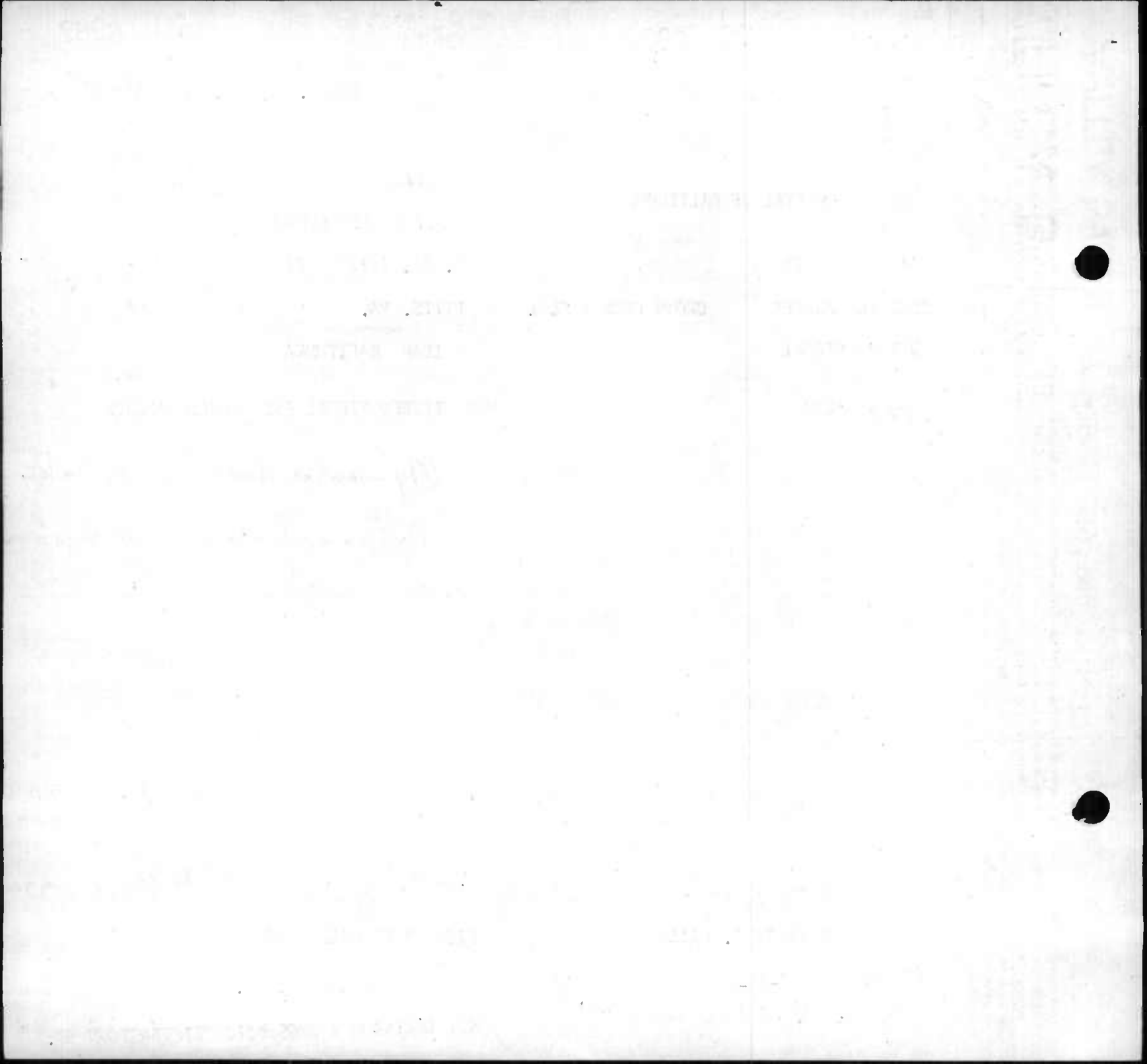
J-520 70 6966		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. [REDACTED]
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES J. JONES		2. DATE AND HOUR OF DEATH 7-6-70 3:58 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY ADNE ARUNDEL		
FULL NAME OF HOSPITAL OR INSTITUTION 435 SOUTH BALTIMORE GEN. HOSPITAL		C. CITY OR TOWN Pasadena		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 236 Wanda Rd. Riviera Beach 5200				
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-18	9. AGE (In years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ticket Agent		10B. KIND OF BUSINESS OR INDUSTRY Greyhound Bus Co.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES E. JONES		
14. MOTHER'S MAIDEN NAME MARY E. LOCKBAUM		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		
16. SOCIAL SECURITY NO. 160-18-6286		17. INFORMANT Olivia E. Jones ADDRESS Same		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) HEPATIC FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. TERMINAL CARCINOMA OF COLON		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 1 Nov 68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 7-5-70 to 7-6-70 that (I) (we) last saw the deceased alive on 7-6-70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Grandma A. Arnes		23B. DATE SIGNED 7-6-70		23C. PHYSICIAN'S NAME (Type) DEGREE
23D. ADDRESS DEGREE				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/9/70		24C. NAME of CEMETERY or CREMATORY Mt. Pleasant Cemetery
24D. LOCATION (City, town, or county) (State) Franklyn Co. Penna.				
25A. DATE REC'D BY HEALTH DEPT. JUL 15 1970		25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR 4001 Ritchie Hgy. Baltimore, Md. 21225



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

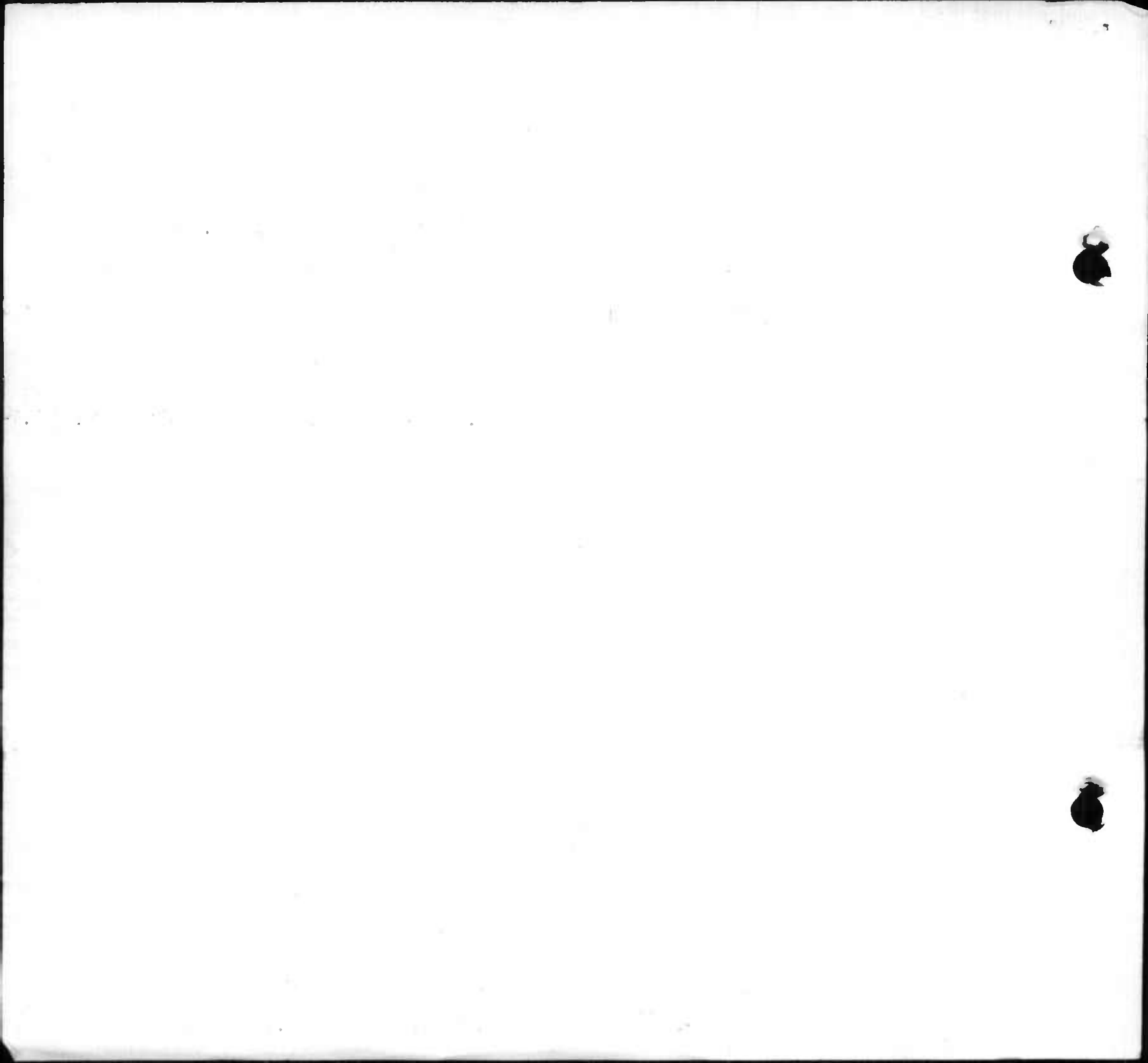
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6967</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>ABRAHAM SIEGEL</u>		2. DATE AND HOUR OF DEATH <u>THURS. JULY 9, 1970 4:35 p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>12 SINAI HOSPITAL OF BALTIMORE</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5327 HAMLIN AVENUE</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 21, 1918</u>	9. AGE (In years last birthday) <u>51</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE MANAGER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CROWN CORK & SEAL</u>		11. BIRTHPLACE (State or foreign country) <u>PITTS. PA.</u>
13. FATHER'S NAME <u>NATHAN SIEGEL</u>		14. MOTHER'S MAIDEN NAME <u>LEAH KAPITUNKA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>WW 2 ARMY</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS MILDRED SIEGEL 5327 HAMLIN AVENUE</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>410.9 I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>July 9, 1970</u> to <u>July 9, 1970</u>, that (I) (we) lost saw the deceased alive on <u>July 9, 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>David I. Miller M.D.</u>				23B. DATE SIGNED <u>July 10 - 1970</u>
23C. PHYSICIAN'S NAME (Type) <u>DR DAVID I. MILLER</u>		23D. ADDRESS <u>2106 CARTERDALE ROAD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-10-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>PETACH TIKVAH</u>
24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS 6010 REISTERSTOWN RD.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

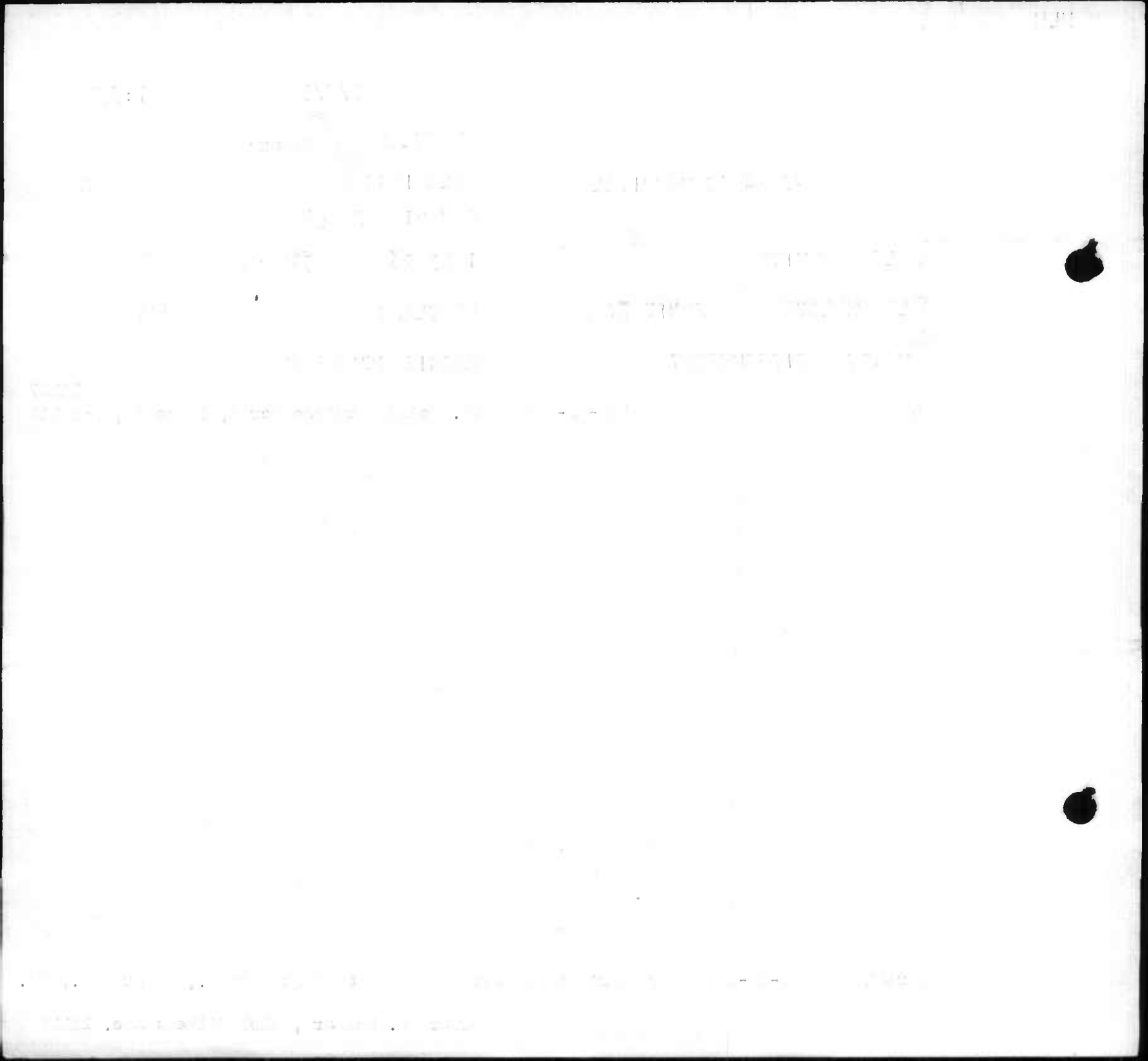
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>70 6968</u>	
B-626 BIRTH NO. <u>70-11568</u> <u>70</u> <u>6968</u>							
1. NAME OF DECEASED (Type or Print) <u>Infant Boy Berger</u>				2. DATE AND HOUR OF DEATH <u>7/8/70</u> <u>3:10 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Sinai of Baltimore</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2720</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai of Baltimore</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3703 SEVEN MILE LANE, APT. T-C1</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/70</u>	9. AGE (In years last birthday) <u>3 hours</u>	10. Under 1 Yr. Months: Days: <u>3</u> <u>30</u>	11. Under 24 Hrs. Hours: Min. <u>3</u> <u>30</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>RONALD BERGER</u>				14. MOTHER'S MAIDEN NAME <u>PAULA SWITZENBAUM</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. RONALD BERGER, 3703 SEVEN MILE LANE, APT. T-C1</u>			
18. <u>7769 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Apnea</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Prematurity</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Apnea</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Prematurity</u> (C) <u>None</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u>							
19A. DATE OF OPERATION <u>9-10-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/8</u> <u>1970</u> to <u>7/8</u> <u>1970</u> and that (I) (we) lost saw the deceased alive on <u>7/8</u> <u>1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Victoria Schauf</u>				23B. DATE SIGNED <u>7/8/70</u>			
23C. PHYSICIAN'S NAME (Type) <u>SINAI HOSPITAL</u>				23D. ADDRESS <u>BALTIMORE, MARYLAND</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>9-10-70</u>		24C. NAME OF CEMETERY or CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>				25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

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MLM		B-632 70 6969		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 70 6969	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN A BREITSCHWERDT				2. DATE AND HOUR OF DEATH 7/9/70 7:55A			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Howard 6300			
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 1 23 96		9. AGE (In years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED						10B. KIND OF BUSINESS OR INDUSTRY FRUIT STAND		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME JOHN HENRY BREITSCHWERDT						14. MOTHER'S MAIDEN NAME MAGGIE SCHROEDER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. 219-05-4940		17. INFORMANT ADDRESS 21227 Mrs. Nellie Breitschwerdt, Route 4, Box 218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.91x250.9 CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ventricular fibrillation (B) DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction (C) ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs. 7 hrs. 4 yrs.									
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes mellitus									
19A. DATE OF OPERATION July 4, 70						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Impending gangrene of foot		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from June 26 19 70 to July 5 19 70 that (it) (we) last saw the deceased alive on July 5 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (it) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Guthrie Malaisrie MD						23B. DATE SIGNED July 9, 70			
23C. PHYSICIAN'S NAME (Type) GUTHRIE MALAISRIE MD						23D. ADDRESS St. Agnes Hosp. Balto Md 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-1970		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Washington Blvd., Howard Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6970	
70 6970				70 6970	
BIRTH NO. A-450				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ALLEN Arthur Leroy			2. DATE AND HOUR OF DEATH 7-7-70 1 4:30 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 1348 5. CITY OR TOWN Baltimore 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 2602 Bueno Vista		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-19	9. AGE (In years lost birthday) 50	10. CITIZEN OF WHAT COUNTRY? U. S. A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker (Checker)			10B. KIND OF BUSINESS OR INDUSTRY Steel Mfg.		
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Arthur Allen			14. MOTHER'S MAIDEN NAME Margaret Jackson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes			16. SOCIAL SECURITY NO. 11-27-41 to 10-14-45 218-01-86-71		
17. INFORMANT VA Hospital Records			ADDRESS Baltimore, Maryland 21218		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> (A) IMMEDIATE CAUSE Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic cardio vascular disease years DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellites years </div> <div style="width: 5%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (u) (this hospital) attended the deceased from June 22, 19 70 to July 7, 19 70 that (u) (we) last saw the deceased alive on July 7, 19 70 and that in (u) (our) opinion death occurred on the date and hour and from the causes stated above. (u) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald S. Pototsky M.D.				23B. DATE SIGNED 7-8-70	
23C. PHYSICIAN'S NAME (Type) RONALD S. POTOTSKY M.D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jul 11 70		24C. NAME OF CEMETERY or CREMATORY Moreland Mem Park	
24D. LOCATION (City, town, or county) (State) Taylors Ave Bk Hb 21234		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970			
25B. NAME OF REGISTRAR Robert E. Valley M.D.		25C. FUNERAL DIRECTOR Burgess Funeral Home Bk Hb Md			

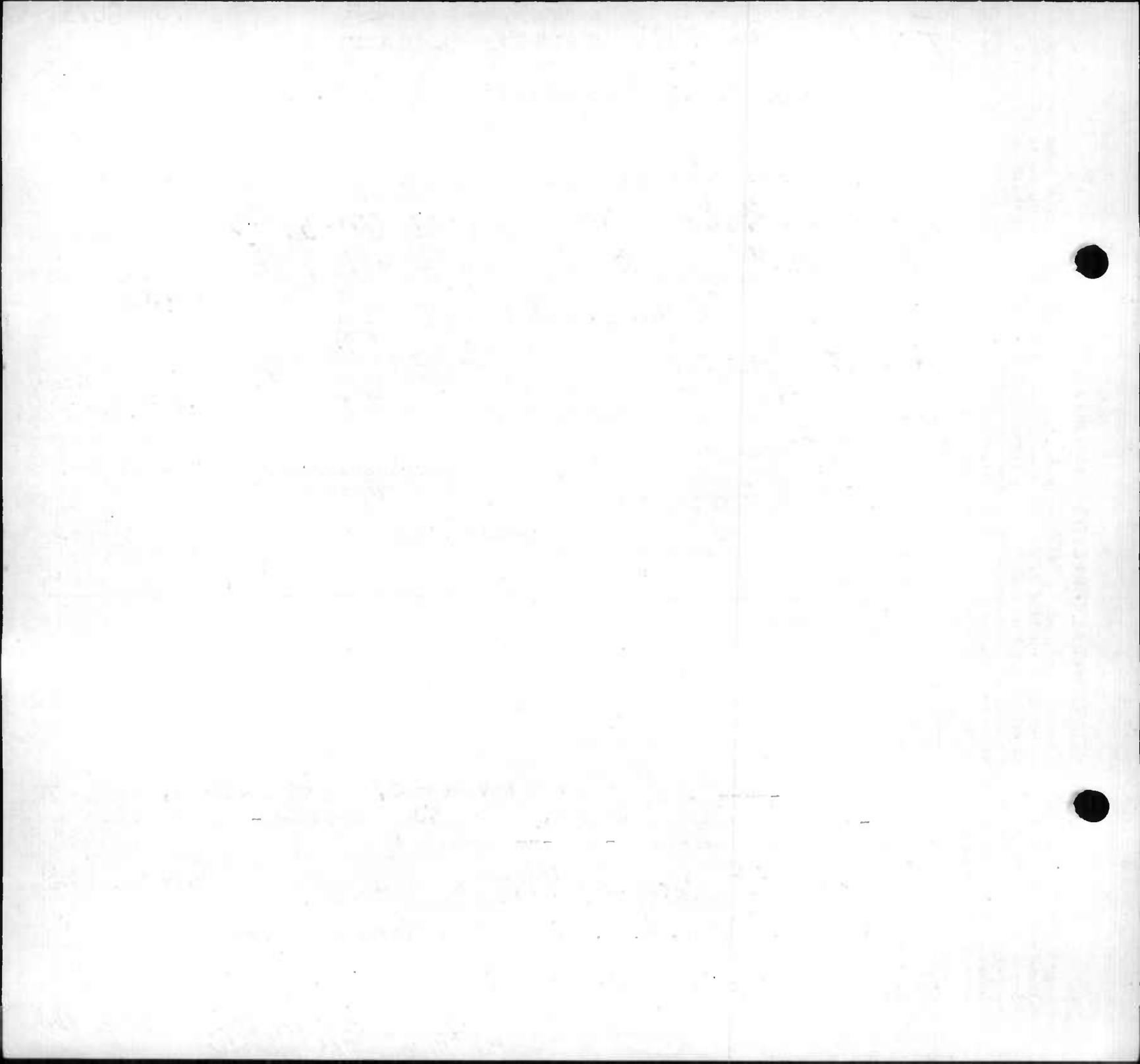
3602 Buena Vista Ave.

(Telephone Directory)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

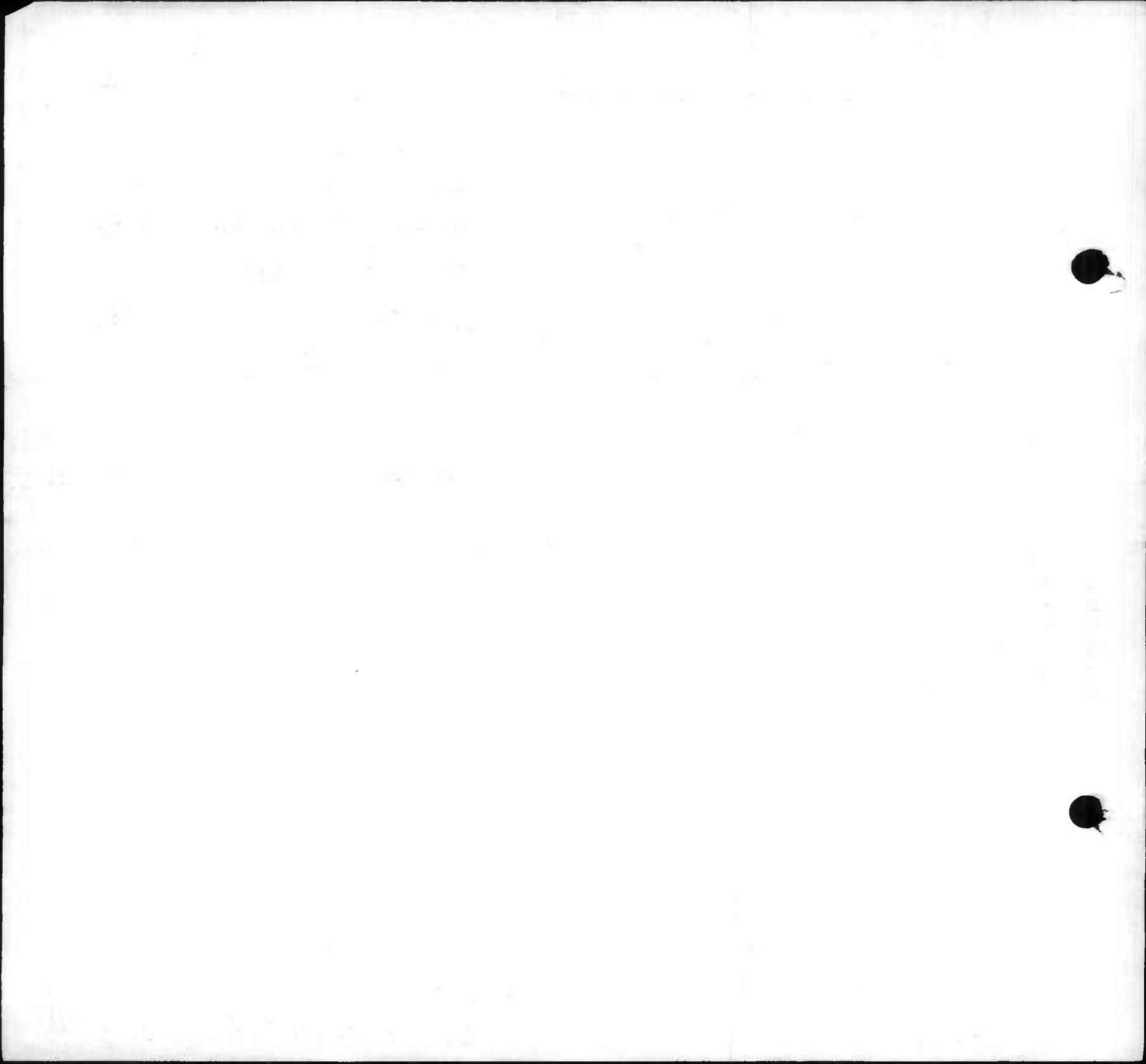
F-163 70 6971				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6971	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) James R FAVORITE				2. DATE AND HOUR OF DEATH 6 July 70 6⁵⁰ P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY 1348			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Ardleigh Nursing Home 2095 Rockrose Ave				C. CITY OR TOWN Bz/Ho		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1229 Union Ave			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 Oct 1891	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder				10B. KIND OF BUSINESS OR INDUSTRY Cotton Duck Mill		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Arthur Favorite				14. MOTHER'S MAIDEN NAME Eliza Phillips			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213 05 0489A		17. INFORMANT Edgar A. Euler Jr	
				ADDRESS 21207			
18. CAUSE OF DEATH 412.4				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardio-vascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF			
				(B) Peptic ulcer DUE TO, OR AS A CONSEQUENCE OF:		5 yrs.	
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from November 2, 19 68 to July 6, 19 70 , that (I) (we) last saw the deceased alive on July 6, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Lloyd E. Saylor M.D.						23B. DATE SIGNED July 10, 1970	
23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor, M. D.						23D. ADDRESS 3902 Greenmount Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE July 10 70		24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Woodbury Bz Ho Co Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Saylor		25C. FUNERAL DIRECTOR Burpee Funeral Home		ADDRESS Bz/Ho Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

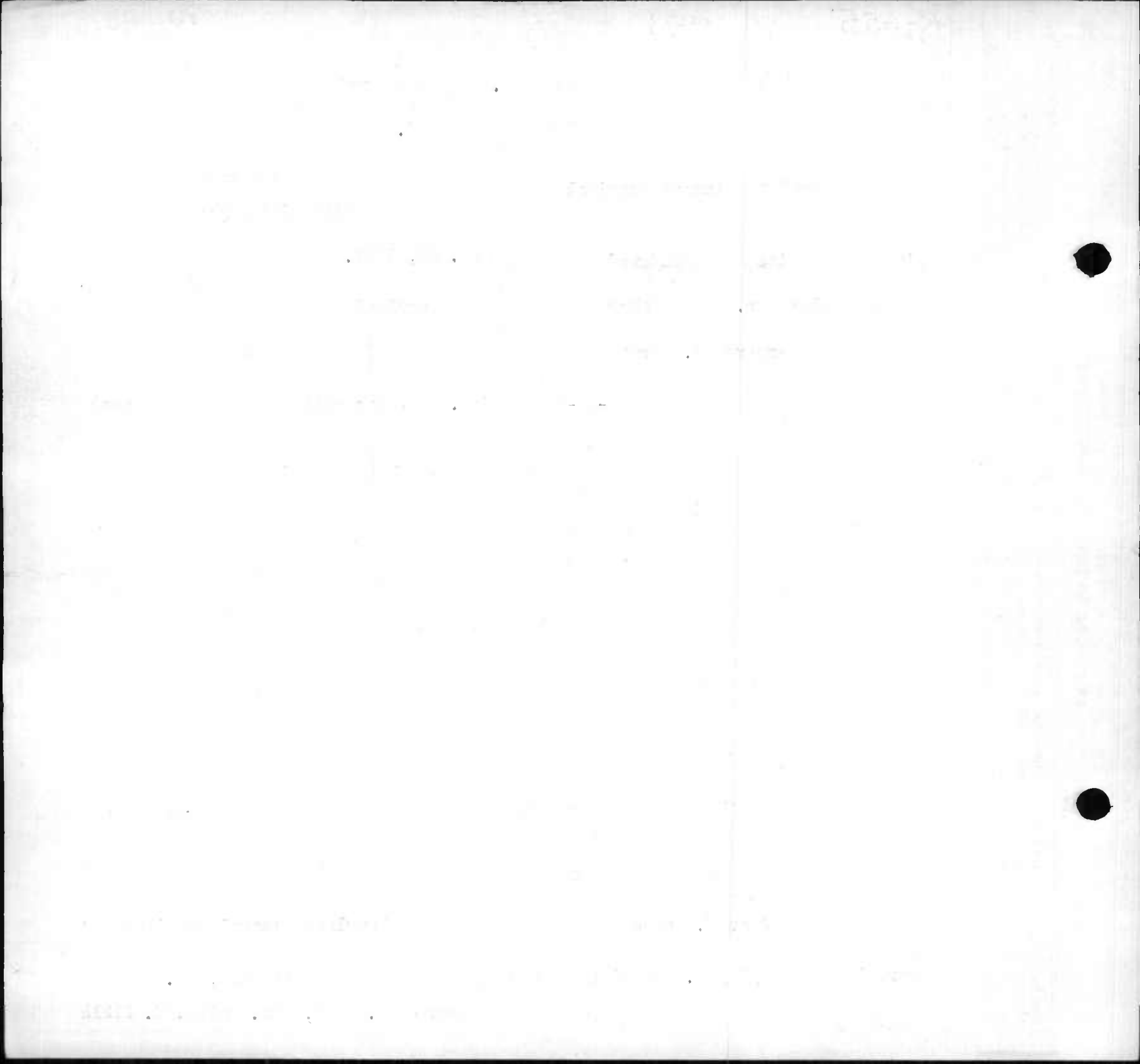
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
I-655		70 6972		70 6972	
1. NAME OF DECEASED (Type or Print) <u>MR. JOHN E FREYMAN</u>			2. DATE AND HOUR OF DEATH <u>7-9-70</u> <u>103⁵⁰ P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Sinai Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1307</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital</u>			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>M</u> 6. RACE <u>W</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-6-04</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool & Die Maker</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Machine Shop</u>		9. AGE (In years last birthday) <u>63</u>
11. BIRTHPLACE (State or foreign country) <u>New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John E Freyman Sr</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Assenheimer</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Address</u>
18. <u>412 R</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ASCVD & Arterial Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>8-10 YEARS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>6-23-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-23-70</u> to <u>7-9-70</u> that (I) (we) last saw the deceased alive on <u>7-9-70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ricardo Ruiz</u>			23B. DATE SIGNED <u>7-9-70</u>		23C. PHYSICIAN'S NAME (Type) <u>Ricardo Ruiz</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>Jul 13 1970</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cem</u>
24D. LOCATION <u>Woodlawn Bldg 6 Md</u>			25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>			25C. FUNERAL DIRECTOR <u>Burger Funeral Home Bldg Md</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

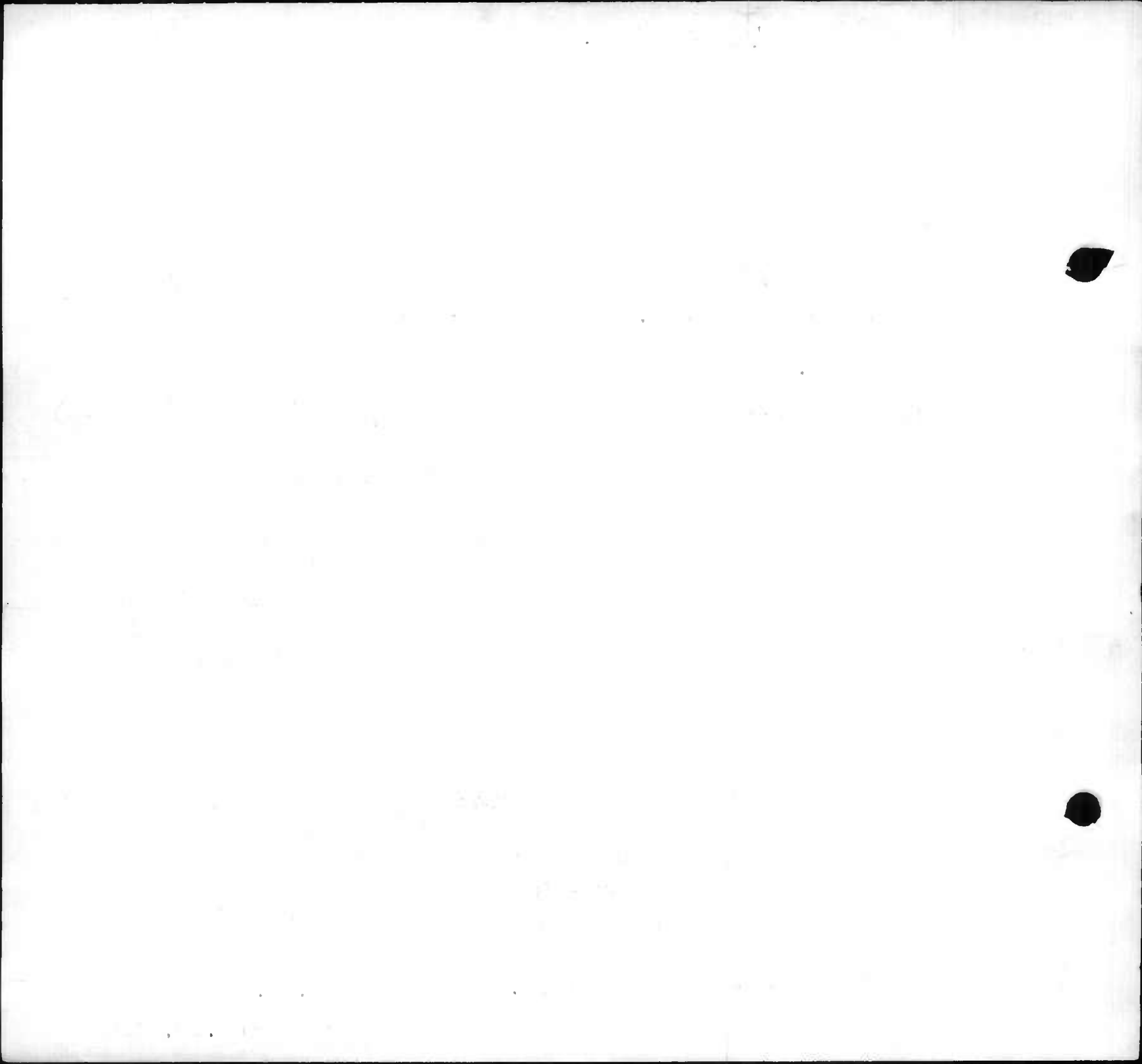
K-655 70 6973		BALTIMORE CITY HEALTH DEPARTMENT		70 6973	
M.E. CASE NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) KERNAN, BERNARD P.		2. DATE AND HOUR OF DEATH 7/9/70 15:48 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5316 Hillen Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Jan. 22, 1887.	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sales Mgr.		10B. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Bernard J. Kernan		14. MOTHER'S MAIDEN NAME Mary Ward	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-1518		17. INFORMANT Mrs. Lorraine Phillips	
18. 430X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolus		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. COAD					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21A. DATE OF OPERATION 7/9/70		21B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 6/9/70 to 7/9/70 , that (I) (we) last saw the deceased alive on 7/7/70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Juan W. Pardo		23B. DATE SIGNED 7/9/70			
23C. PHYSICIAN'S NAME (Type) Juan W. Pardo		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/70.		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

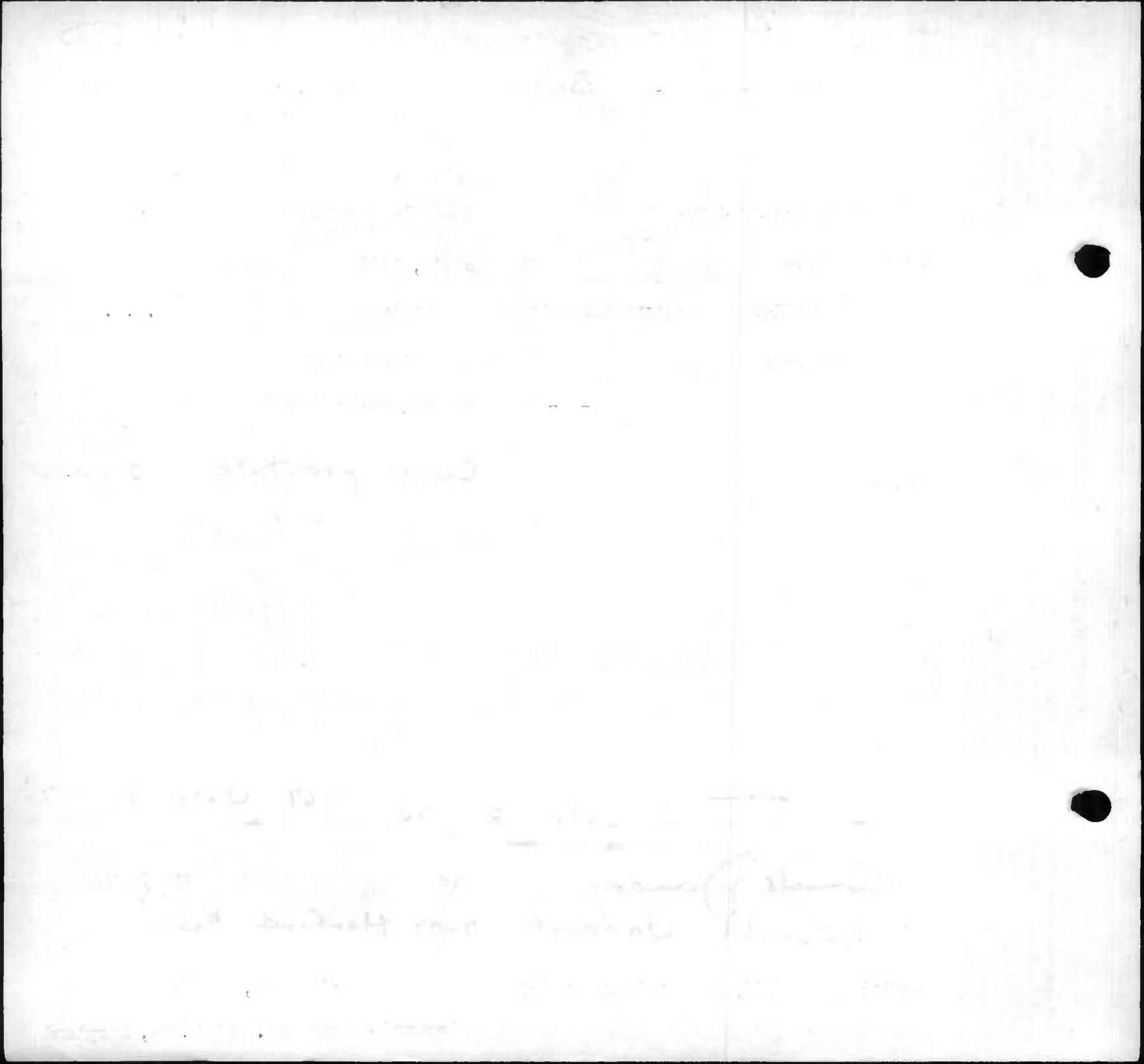
M-252 70 6974		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 70 6974	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JAMES A. MAGNESS JR.		2. DATE AND HOUR OF DEATH 8 July 70 1:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital 35		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>		6. RACE White <input checked="" type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10B. KIND OF BUSINESS OR INDUSTRY Balto. Motor Coach		8. DATE OF BIRTH 10-7-09 9. AGE (In years last birthday) 60 yrs	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME JAMES A. MAGNESS SR.	
14. MOTHER'S MAIDEN NAME MARY WILLINGHAM		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-5506	
17. INFORMANT Eleanor Magness (wife)		ADDRESS (Same)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiopulmonary arrest		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		few min.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Massive acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF:		few days	
(C)					
19. DATE OF OPERATION		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (if this hospital) attended the deceased from July 19 1970 to July 8 1970 that (if we) last saw the deceased alive on July 8 1970 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (if we) (did not) view the body after death.		23A. SIGNATURE Rolando A. Mendoza M.D.		23B. DATE SIGNED 7/8/70	
23C. PHYSICIAN'S NAME (Type) ROLANDO A. MENDOZA M.D.		23D. ADDRESS 402 N. Broadway Balto., Md. 21201		23E. FUNERAL DIRECTOR Leonard J. Buck Inc Balto. Md. 21214	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-70		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.	
24D. LOCATION Balto. Md.		24E. DATE REC'D BY HEALTH DEPT. JUL 13 1970		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. ADDRESS		24H. DATE		24I. NAME OF REGISTRAR	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6975	
B-600 70 6975 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Henry H Behr		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH 7-9-70 11 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3028 Fleetwood Ave			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2745 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3028 Fleetwood Ave		
5. SEX Female 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 14, 1901 9. AGE (In years last birthday) 68 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Installer		10B. KIND OF BUSINESS OR INDUSTRY Western Electric Co		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George W Behr			
14. MOTHER'S MAIDEN NAME Ernestine Ludorf		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 577-07-8549		17. INFORMANT Mrs Margaret A Behr		ADDRESS Same	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cancer prostate					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 07 10 July 9 19 70, that (I) (we) lost saw the deceased alive on July 8 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE R Donald Jandorf				23B. DATE SIGNED 7-9-70	
23C. PHYSICIAN'S NAME (Type) R Donald Jandorf				23D. ADDRESS 7403 Harford Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/13/70		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Jandorf		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6976

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marjorie Ann Fitzsimmons MARJORIE FITZSIMMONS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 SOUTH BALTO. GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year July 8, 1970 Hour 4:15 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7/15/1928		10. AGE (In years last birthday) 41	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 220-22-3576	
15. MOTHER'S MAIDEN NAME Anna Pulkrt		18. INFORMANT ADDRESS Mrs. Anna Leonard 333 N. Charles St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E983X		CAUSE OF DEATH Gunshot wound of head	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bathroom	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 819 Stoll Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 7-7-70 10:30 11:15 P. m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Gunshot wound of head	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7/8/70	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/70	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md.	

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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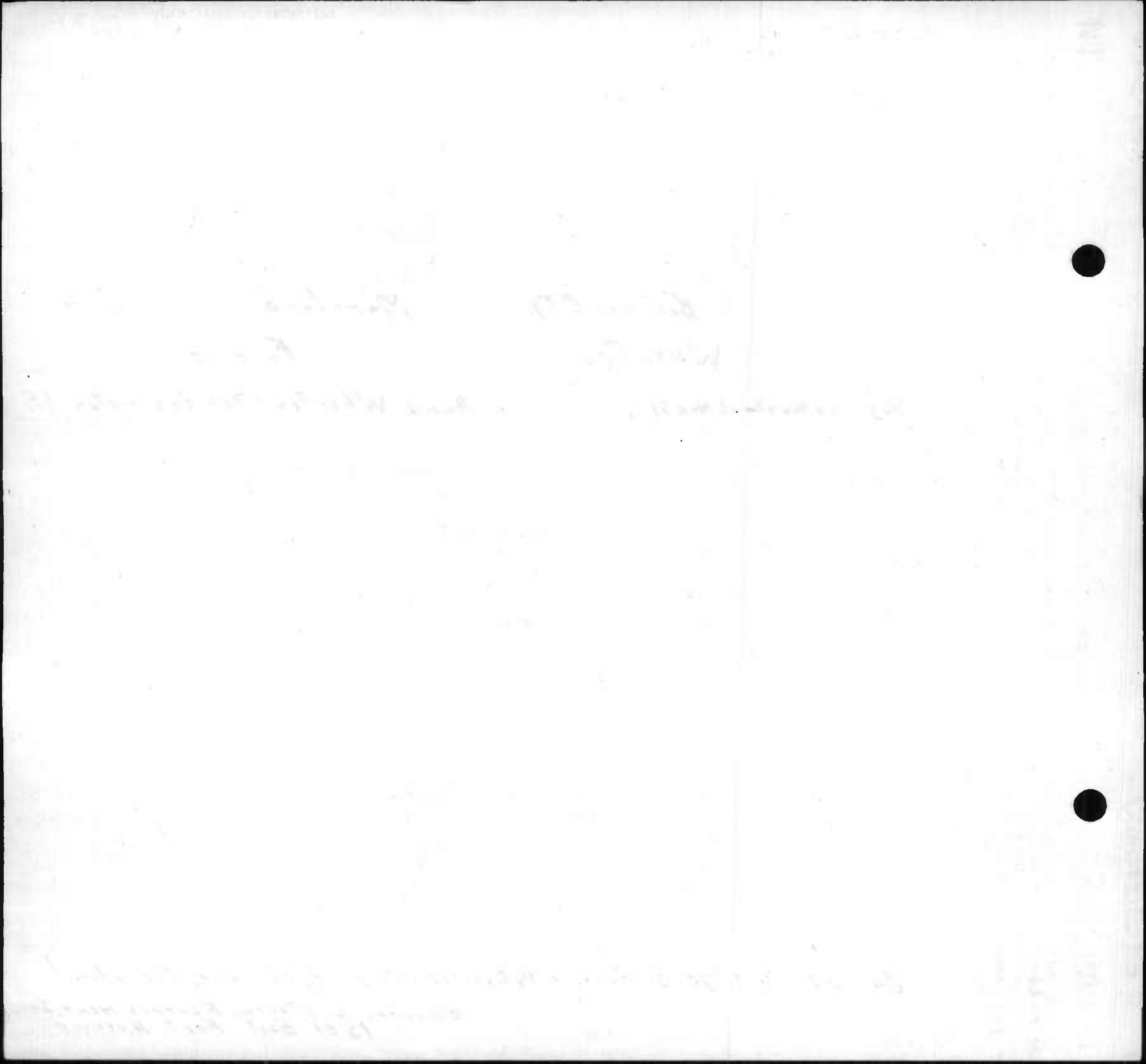
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

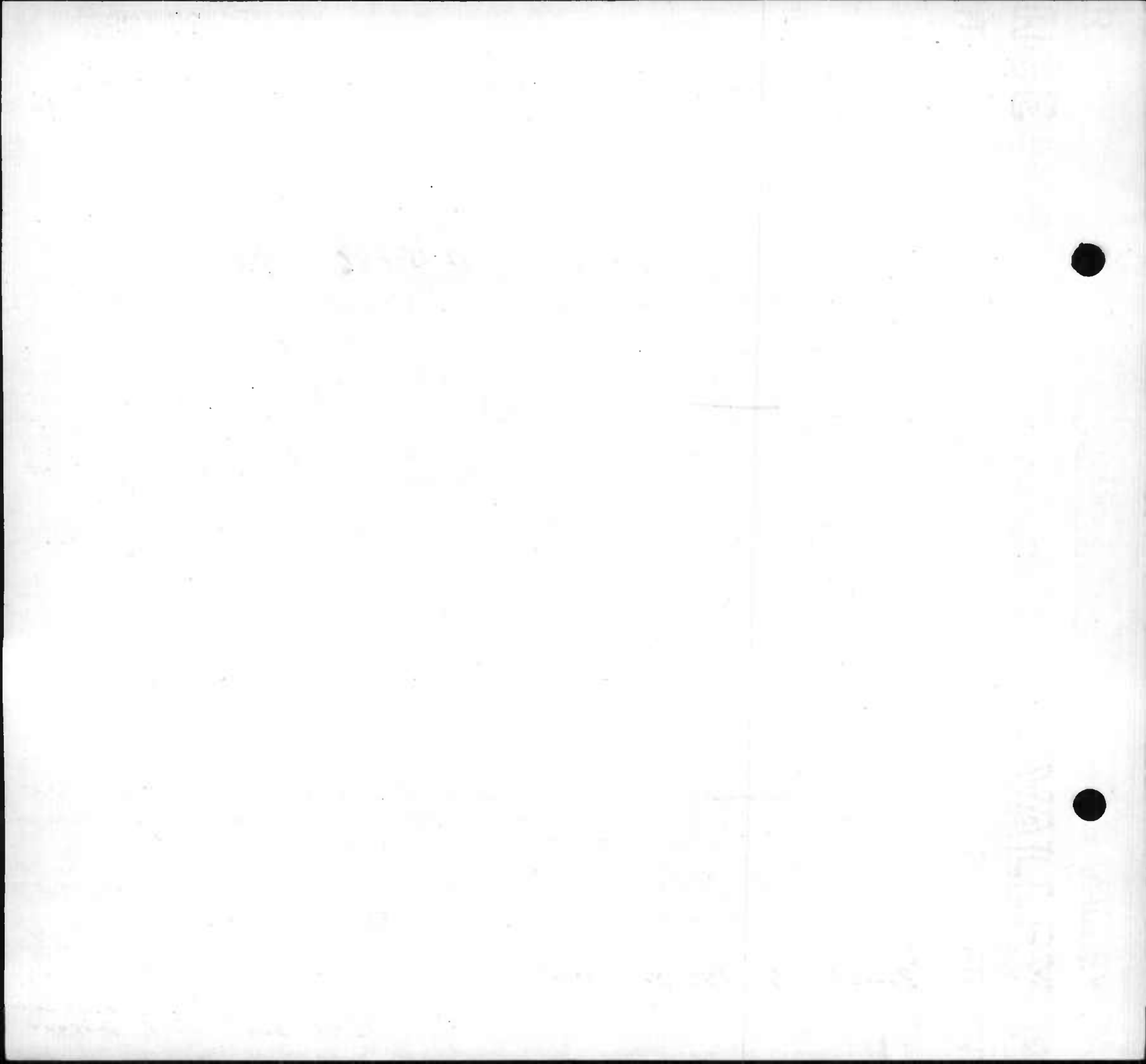
W-635 70 6977				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6977	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Whorton ARNOLD W, Sr</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <u>7/6/70</u> <u>12 35</u> P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2404</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE MD</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1711 Covington St</u>			
5. SEX <u>Male</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-26-28</u>	9. AGE (In years last birthday) <u>42</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Gilroy A. Whorton</u>				14. MOTHER'S MAIDEN NAME <u>MARY Friend</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 24 Nov 42-23 Nov 51</u>		16. SOCIAL SECURITY NO. <u>220-20-8342</u>		17. INFORMANT <u>Anna Whorton</u>		ADDRESS <u>1711 Covington ST.</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIO RESPIRATORY ARREST.</u> (B) <u>ACUTE MI.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CIRRHOSIS OF THE LIVER.</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7/6/70</u> 19 <u>70</u> to <u>7/6/70</u> 19 <u>70</u> , that (I) (we) last saw the deceased alive on <u>7/6/70</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R H Reed</u>				OEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>7-7-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>REED</u>				23D. ADDRESS OEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>7/10/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles E. Stevens Funeral Home, Inc.</u>		ADDRESS <u>1501 East Fort Avenue</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

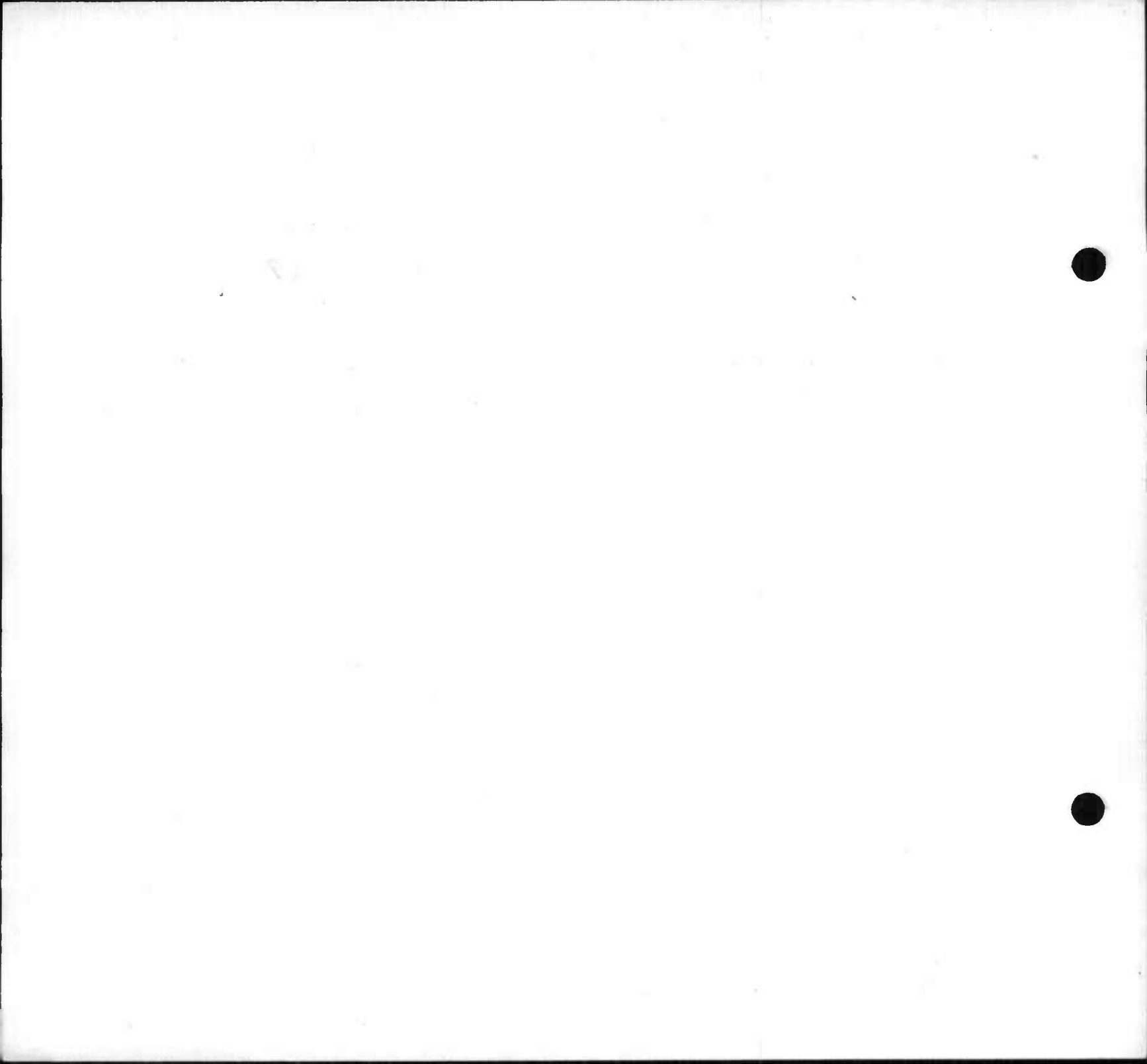
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6978	
BIRTH NO. M-240 70 6978		CERTIFICATE OF DEATH			
1. NAME OF DECEASED <small>(Type or Print)</small> Cecilia (Celia) Agnes McHale			2. DATE AND HOUR OF DEATH 7-10-70 10 A.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> 001305 Humbert street			4. USUAL RESIDENCE <small>(Where deceased lived. If institution; residence before admission)</small> A. STATE Md. B. COUNTY 2401 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1305 Humbert Street 21230		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-15-1886 83	9. AGE <small>(In years last birthday)</small> 83 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> Housewife			10B. KIND OF BUSINESS OR INDUSTRY —		
11. BIRTHPLACE <small>(State or foreign country)</small> Ireland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Michael Barrett			14. MOTHER'S MAIDEN NAME Sheila Flynn		
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> no			16. SOCIAL SECURITY NO. 213-54-0161		
17. INFORMANT Michael McHale (son) ADDRESS same			18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> #12, 21 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE: Cerebro-vascular Accident 2 days (B) DUE TO OR AS A CONSEQUENCE OF: Hypertensive Cardiovascular disease years (C) —		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? <small>(Yes or No)</small> no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <small>(Notify medical examiner)</small> no		21B. PLACE OF INJURY <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small> —		21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small> —	
21D. TIME OF INJURY <small>(Month) (Day) (Year) (Hour) (Approx.)</small> —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 4-15-1967 to 7-10-1970, that (I) (we) last saw the deceased alive on 7-8-1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE C. C. Chiu M.D.				23B. DATE SIGNED 7-10-70	
23C. PHYSICIAN'S NAME <small>(Type)</small> C. C. CHIU, M.D.				23D. ADDRESS 1 E. Randall St. Balto Md. 21230	
24A. BURIAL CREMATION, REMOVAL <small>(Specify)</small> Burial		24B. DATE 7/13/70		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION <small>(City, town, or county) (State)</small> Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR <small>ADDRESS</small> Charles E. Stevens Funeral Home, Inc. 1501 East Fort Avenue			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-164 70 6979		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		70 6979	
1. NAME OF DECEASED (Type or Print) <i>ESTHER BEVERLY M.</i>		2. DATE AND HOUR OF DEATH <i>July 9, 1970 1:15 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hospital 44</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1530 Abbotson Street</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 6, 1901</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>		13. FATHER'S NAME <i>HENRY FREEMAN</i>		14. MOTHER'S MAIDEN NAME <i>ELLEN (unknown)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-32-8703-A</i>		17. INFORMANT <i>Octavia Beverly - 1530 Abbotson St.</i>	
18. <i>456X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>pneumonitis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <i>(1)</i> (this hospital) attended the deceased from <i>06/08/005</i> 19 <i>70</i> to <i>07/09</i> 19 <i>70</i> that (I) <i>(we)</i> last saw the deceased alive on <i>07/09</i> 19 <i>70</i> and that in (my) <i>(we)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> (did) (did not) view the body after death.					
23A. SIGNATURE <i>I. Cheikh</i>		23B. DATE SIGNED <i>07/09/1970</i>		23C. PHYSICIAN'S NAME (Type) <i>ISSAM E. CHEIKH</i>	
23D. ADDRESS <i>Union Memorial Hospital Baltimore 28218</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-14-70</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Calvary</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. STATE <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 13 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. [illegible]</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law</i>	
25D. ADDRESS <i>802 Madison Ave.</i>					



FUNERAL DIRECTOR: IMPORTANT

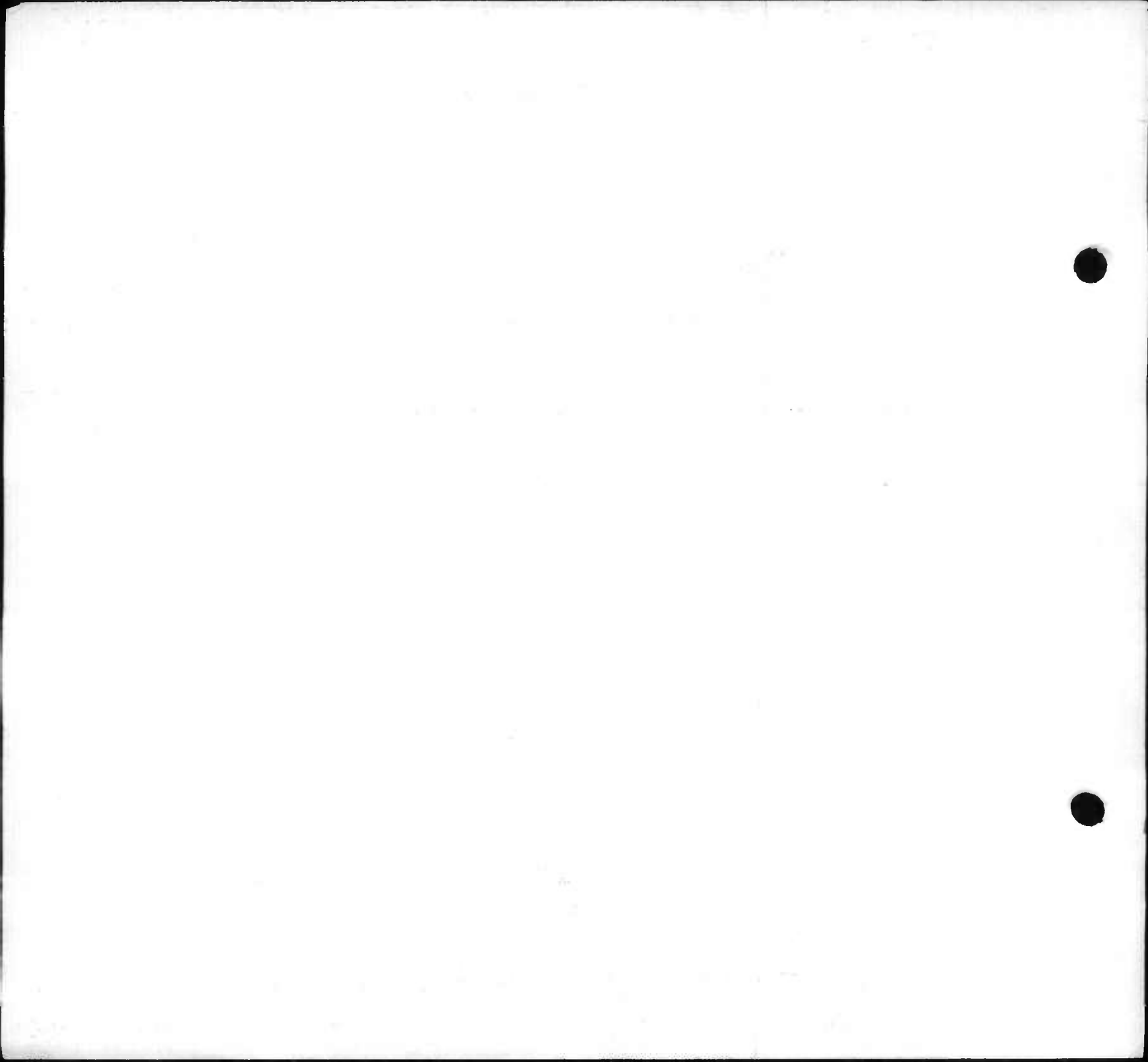
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 6980</u>	
1. NAME OF DECEASED (Type or Print) <u>MANUEL, MATTIE E.</u>		2. DATE AND HOUR OF DEATH <u>7/8/1970 1045 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 MD. Gen. Hospital.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore City</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1024 W. Fayette St Md 21223</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>72/6/1910</u>	9. AGE (In years last birthday) <u>59 yrs</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Spauler</u>			14. MOTHER'S MAIDEN NAME <u>Messina Jones</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-09-0014</u>	17. INFORMANT <u>husband</u> ADDRESS <u>Same as above</u>		
18. <u>433.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA INFARCT</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral infarct</u> <u>Arteriosclerotic cerebro-vascular disease</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral infarct</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic cerebro-vascular disease</u> (C) <u>4 yrs</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6/13/1970</u> to <u>7/8/1970</u> that (I) (we) last saw the deceased alive on <u>7/8/1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M. AL-IBRAHIM</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>M. AL-IBRAHIM</u>		23D. ADDRESS <u>MD. Gen Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-13-70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Charles R. Law</u> ADDRESS <u>802 Madison Ave.</u>	

100 100 100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

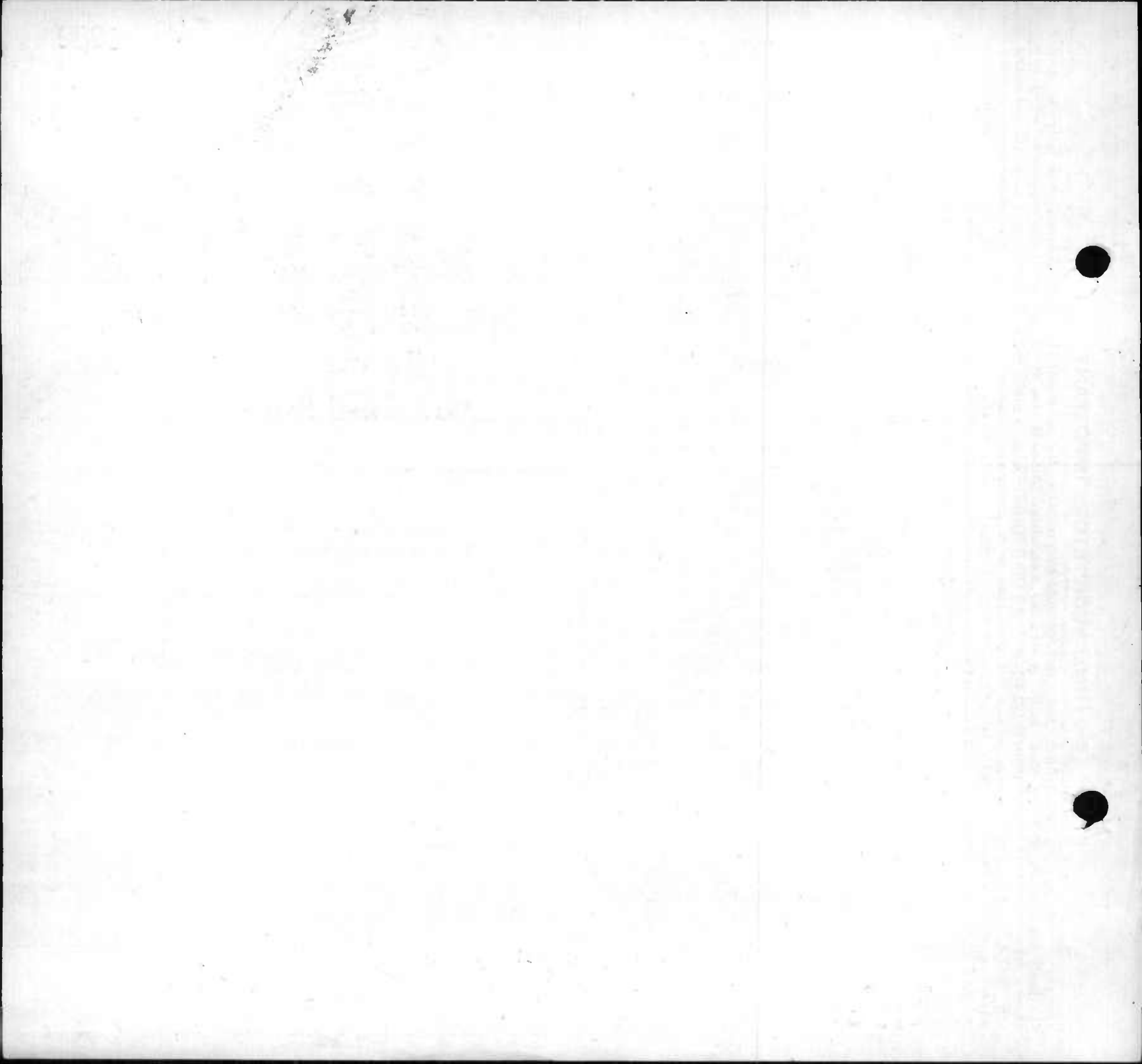
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6981	
CERTIFICATE OF DEATH					
BIRTH NO. 525		70 6981			
1. NAME OF DECEASED (Type or Print) <i>Mr. JAMES A. JAMISON (Jamieson)</i>			2. DATE AND HOUR OF DEATH <i>JULY 12, 1970 0:40 AM</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>BON SECOURS HOSPITAL</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BON SECOURS HOSPITAL</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>male</i>			6. RACE <i>USA (CAH)</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>07/24/15</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rigger</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Shipyard</i>		9. AGE (In years last birthday) <i>54 yrs</i>
13. FATHER'S NAME <i>Unknown.</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Scotland</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>231-36-4672</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
15. Informant <i>Mrs Nemo Jamieson</i>			ADDRESS <i>1722 W. Pratt St. Balto. Md.</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <i>congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial Infarction</i> (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Achalasia of Esophagus</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>weeks</i> <i>- years</i> <i>years</i>		
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>-</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>-</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>06/26/1970</i> to <i>07/12/1970</i> that (I) (we) last saw the deceased alive on <i>07/11/1970</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Kusuma K. Pruksapong MD</i>			23B. DATE SIGNED <i>7/12/70</i>		23C. PHYSICIAN'S NAME (Type) <i>DR. KUSUMA K. PRUKSAPONG MD</i>
23D. ADDRESS <i>BON SECOURS HOSPITAL</i>			23E. DATE SIGNED <i>7/12/70</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/15/70</i>		24C. NAME of CEMETERY or CREMATORY <i>Fort Hill Mem. Cem.</i>	
24D. LOCATION <i>Lynchburg Campbell Va.</i>		24E. NAME of REGISTRAR <i>Robert E. Fisher, MD</i>		24F. FUNERAL DIRECTOR <i>George L. Schwab Inc Balto., Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JUL 13 1970</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, MD</i>		25C. FUNERAL DIRECTOR <i>George L. Schwab Inc Balto., Md.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260 70 6982				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6982	
1. NAME OF DECEASED (Type or Print) <u>Jackson Linwood Baker</u>				2. DATE AND HOUR OF DEATH <u>July 11 1970</u> <u>8</u> <u>pm</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Pleasant Manor Nursing Home</u> <u>Liberty Heights Ave 4576</u>				A. STATE <u>Baltimore Md.</u>		B. COUNTY <u>Baltimore</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Balto. Md.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>202</u>							
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/25/25</u>	9. AGE (In years last birthday) <u>45</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Air Force</u>		11. BIRTHPLACE (State or foreign country) <u>Grafton. W Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Pittman</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Ann Baker Hanna</u>			
18. <u>146.0</u> I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cor of Tonsils</u>				<u>6 wks.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>C metastases to neck</u> DUE TO, OR AS A CONSEQUENCE OF:				<u>4 wks.</u>	
(C) <u>1 brain</u>							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>June 12</u> 19 <u>70</u> to <u>July 11</u> 19 <u>70</u> , that (I) (we) lost saw the deceased alive on <u>July 2</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Harry B. Scott</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>7-11-70</u>	
23C. PHYSICIAN'S NAME (Type) <u>Harry B. Scott</u>				23D. ADDRESS <u>721 Medical Arts Bldg 21201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/15/70</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>		24D. LOCATION (City, town, county) (State) <u>Balto. Md.</u>	
25A. DATE RECD BY HEALTH DEPT. <u>JUL 18 1970</u>		25B. NAME OF REGISTRAR <u>John E. Taylor</u>		25C. FUNERAL DIRECTOR <u>George L. Schwab, Inc.</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6983		REG. NO. 70 6983	
BIRTH NO.				70 6983			
1. NAME OF DECEASED (Type or Print) ANNIE ANNIE D. BROWN				2. DATE AND HOUR OF DEATH 7/10/70 4 15 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY 808			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CENTURY NURSING HOME				C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1238 N. WASHINGTON ST							
5. SEX F.	6. RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/27/1899	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME HATTIE DRAKE				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 230-42-6984		17. INFORMANT Louise M. Bishop		ADDRESS 1238 N. Washington St
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio Respiratory Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVD Stokes Adams Syndrome (B) DUE TO, OR AS A CONSEQUENCE OF: Transient Cerebral Ischemia (C) UNDERLYING CONDITION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION ?		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 16 19 70 to July 10 19 70 , that (I) (we) last saw the deceased alive on July 10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Willard Appleford						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Willard Appleford						23D. ADDRESS 6615 Reisterstown Rd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/70		24C. NAME OF CEMETERY OR CREMATORY CARVER MEM. PK.		24D. LOCATION (City, town, or county) (State) LAUREL, Md	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Joseph C. Locks		ADDRESS 1304 N. Central Ave	

Thomas & Charles Johnson
 1012 1/2 1st St
 Astoria, Ore.
 Charles Johnson, Jr.
 1012 1/2 1st St

Willard Appleton
 1012 1/2 1st St
 Astoria, Ore.
 June 10 1910

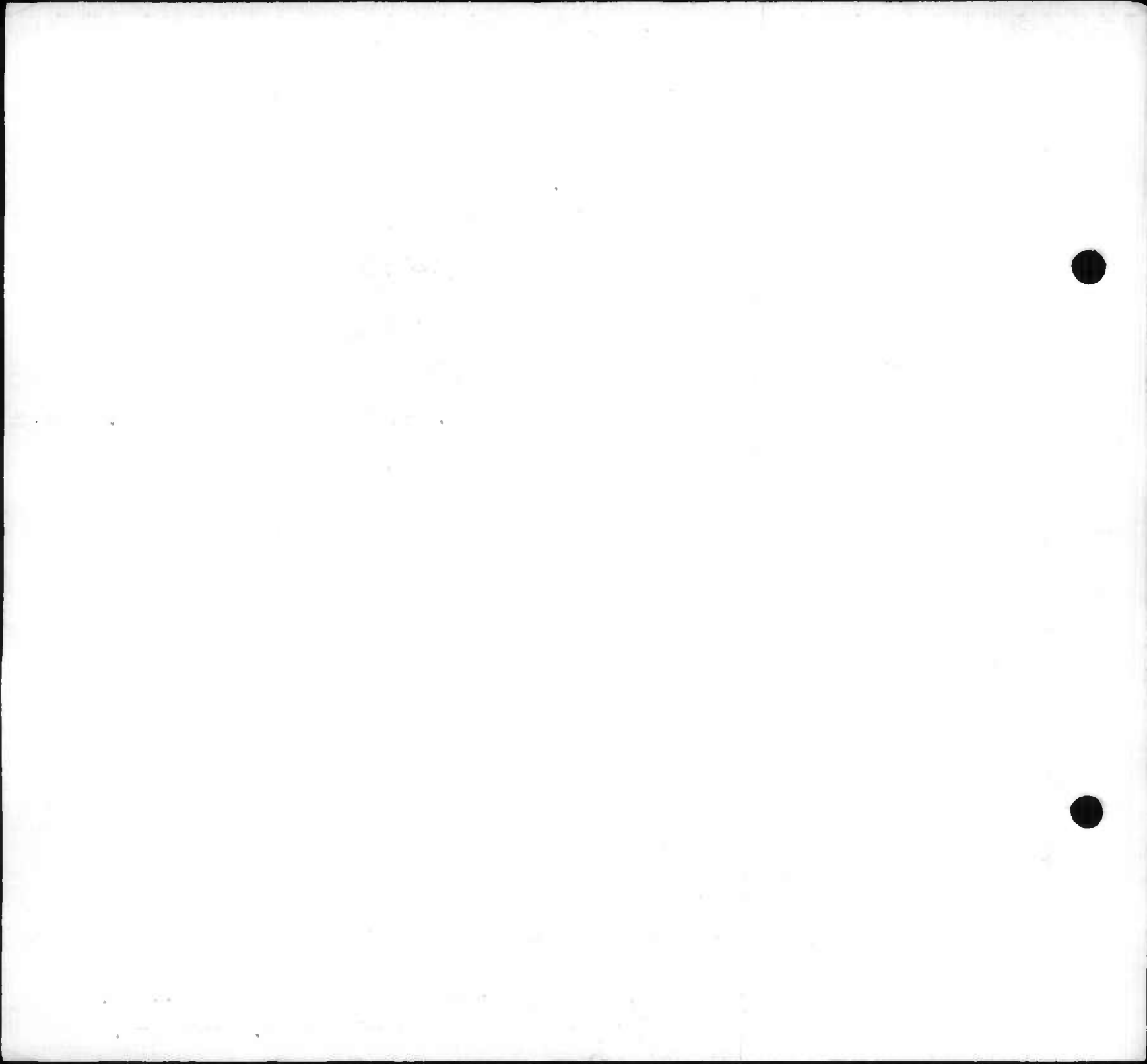
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 70 6984		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 70 6984	
1. NAME OF DECEASED (Type or Print) James T. Ramsey		2. DATE AND HOUR OF DEATH 7-8-70 6:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 5300			
5. SEX Male		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 10, 1909		9. AGE (In years last birthday) 61		10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10B. KIND OF BUSINESS OR INDUSTRY Banking		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wm B. Ramsey		14. MOTHER'S MAIDEN NAME Louise Banning	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 290054392		17. INFORMANT Mrs. Kyoko Ramsey	
18. 15301 CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE TERMINAL CANCER		DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) Metastatic carcinoma		24h vs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Carcinoma Caecum			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Severe malnutrition & weight loss			
19A. DATE OF OPERATION 16-18-70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED C.B.D. OBSTN.		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nality medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 15th June 1970 to 7th July 1970 that (I) (we) lost saw the deceased alive on 7th July 1970 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 7-8-70		23C. PHYSICIAN'S NAME (Type) H. S. RANGANATH, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-10-70		24C. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	
24D. LOCATION (City, town, or county) Bell Centre, Ohio		24E. LOCATION (State) Ohio		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970	
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR [Signature]		25D. ADDRESS [Address]	

None received from Mercy Hospital - 7-15-70 J.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

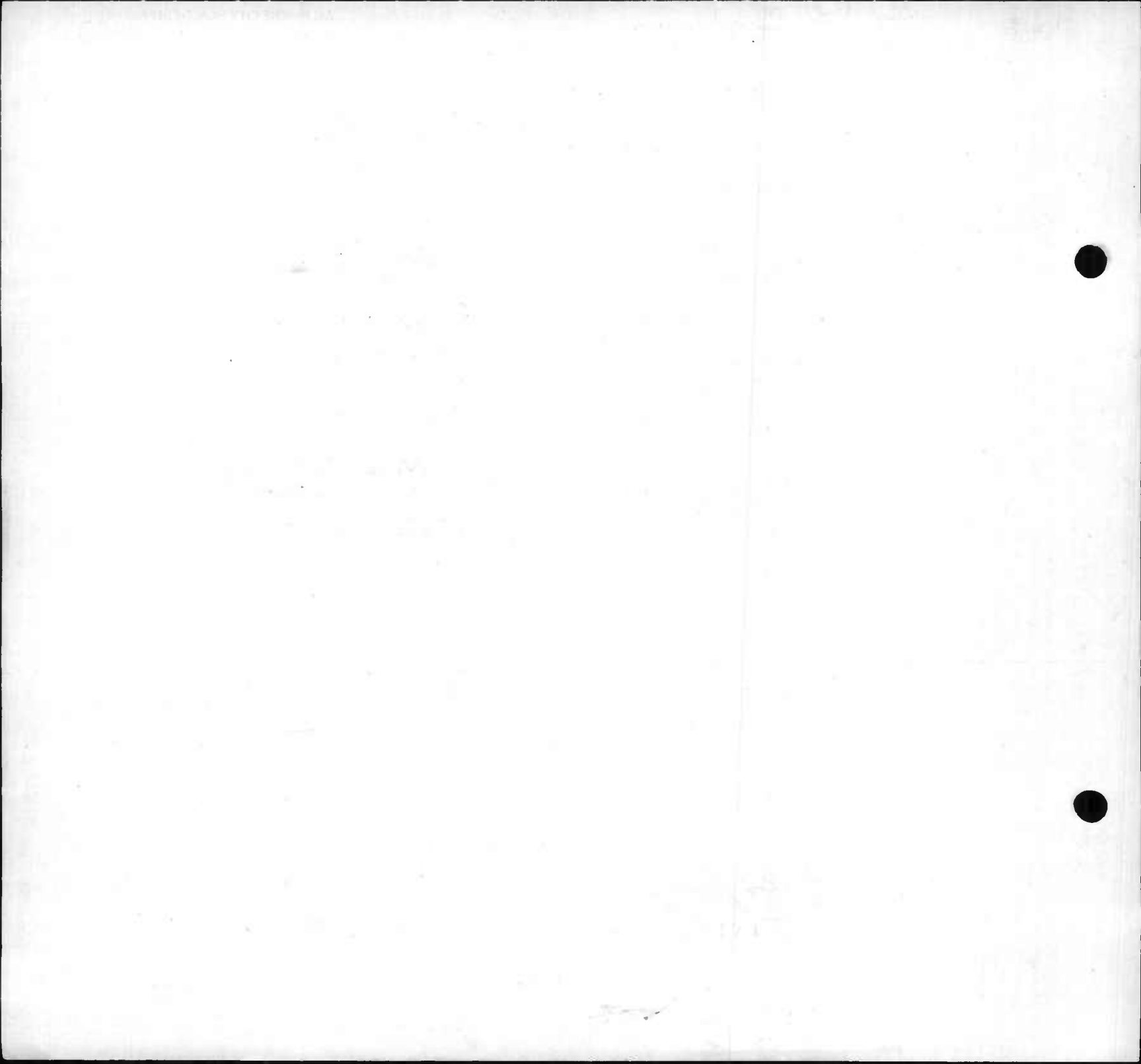
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6985	
70 6985				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Gosbarn, Virginia</u>		2. DATE AND HOUR OF DEATH <u>July 7, 1970 19:15 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1001</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1048 N. Eden Street</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/25/95</u>		9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Monroe Neblett</u>			14. MOTHER'S MAIDEN NAME <u>Annie</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Hazel Westmoreland 718 E. 21st St</u>	
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Overwhelming Infection</u> 5 days DUE TO, OR AS A CONSEQUENCE OF: (B) <u>severe diabetes with Gungame</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 30 1970</u> to <u>July 7 1970</u> that (I) (we) last saw the deceased alive on <u>July 7 1970</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert A. Vigersky, M.D.</u>			23B. DATE SIGNED <u>July 7, 1970</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert A. Vigersky, M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>7/10/70</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty., Md.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		
25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>			25C. FUNERAL DIRECTOR <u>Wm C March 928 E. North Ave.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

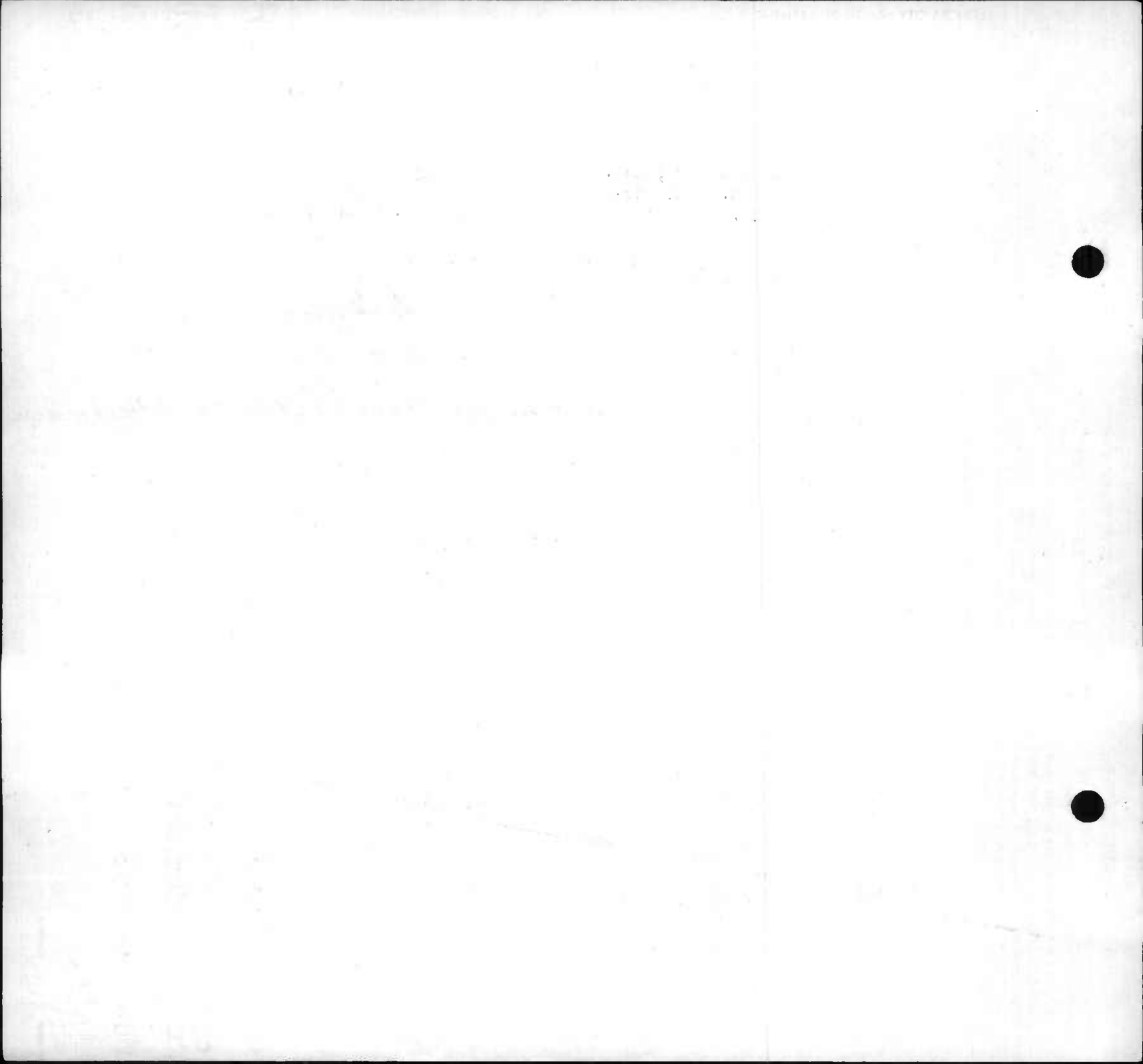
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6986	
70 6986				X	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY SIEMON		7-8-70 5:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
South Baltimore General Hospital				Md. Anne Arundel 5200	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Riviera Beach YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER	
				8573 Bay Road	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)
F	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12-20-1901	68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife					Maryland
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John E. Smith			Lillian E. Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Hospital record
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				M.I. (MYOCARDIAL INFARCTION)	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DIABETES MELLITUS.	
				(C) _____	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 7/7 1970 to 7/8 1970, that (I) (we) last saw the deceased alive on 7/8 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				7-8-70	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ESPINOZA MD				3001 S. Hanover St Balto Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		7-11-70		Glen Haven Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Glen Burnie 21061, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JUL 13 1970		Robert E. Taylor, M.D.		John N. Hahn, 4200 Pennington Ave 21226	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

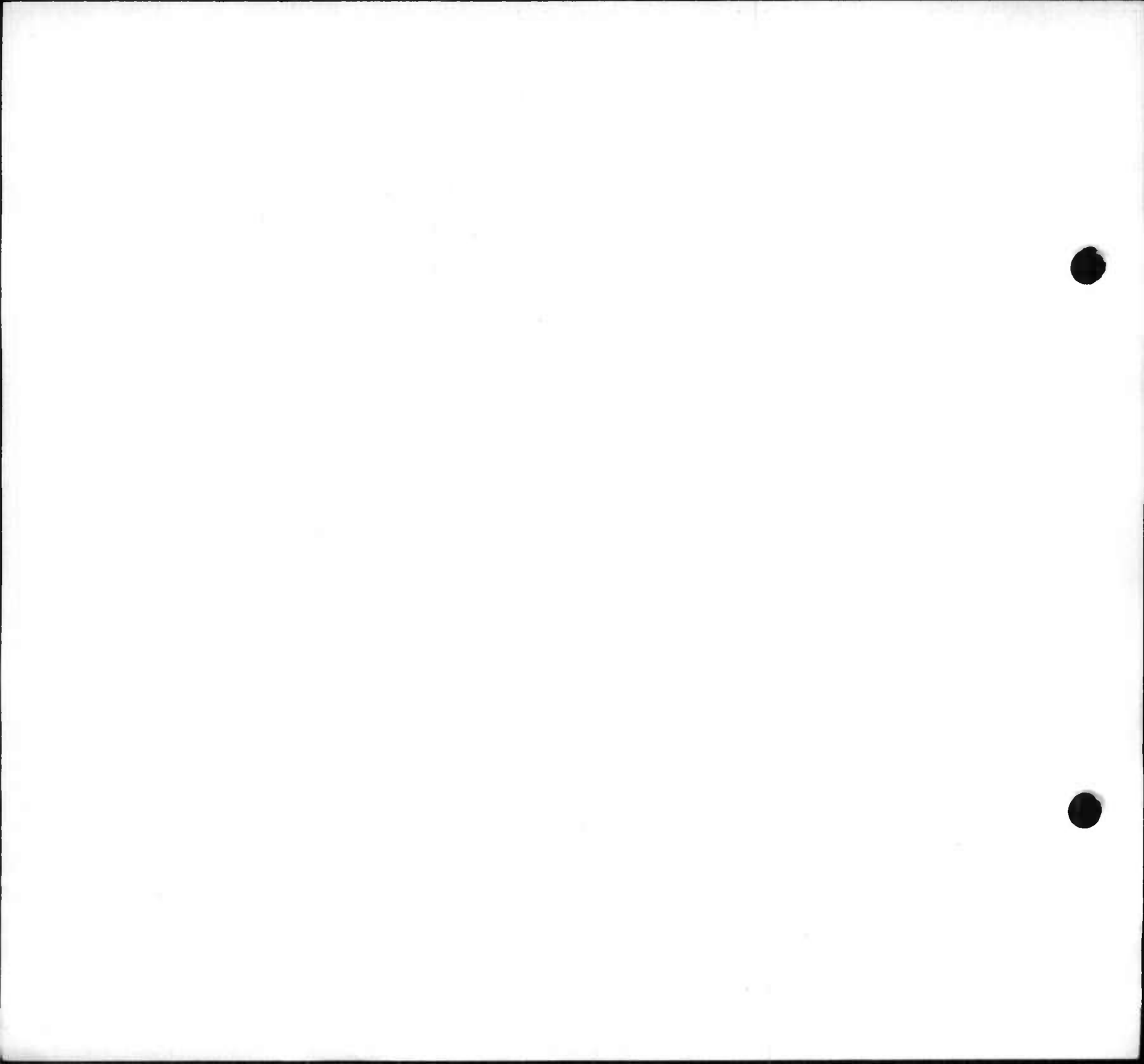
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6987	
BIRTH NO. 70 6987		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mary Edwards		2. DATE AND HOUR OF DEATH July 3, 1970 4:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Midtown Home, Inc. 808 St. Paul Street Balto. Md 21202		A. STATE Md		B. COUNTY 908	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1101 E. 20th Street			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/92	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. Carolina	
13. FATHER'S NAME Wyle Smith		14. MOTHER'S MAIDEN NAME Mary Smith			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-12-0555		17. INFORMANT Mrs. Marie Edwards	
				ADDRESS 2824 Harbor Ave.	
18. 412.41		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Cardio-Respiratory Failure			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Senility			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/31 19 68 to 7/3 19 70 , that (I) (we) last saw the deceased alive on 19 and that in (my) () opinion death occurred on the date and hour and from the causes stated above. (I) () (did not) view the body after death.					
23A. SIGNATURE William D. Appleberry				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) William D. Appleberry				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-7-70		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) North Baltimore		24E. (State) Md			
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph R. Luce	
				ADDRESS 2222 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6988	
BIRTH NO. 70 6988				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Annie Laura Gray</i>			2. DATE AND HOUR OF DEATH <i>July 4, 1970</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Mt. Sinai Nursing Home</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>628 N. Fremont Ave.</i>		
5. SEX <i>Female</i>	6. RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 1, 1895</i>	9. AGE (In years last birthday) <i>75</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Mins.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Joseph Beraul</i>			14. MOTHER'S MAIDEN NAME <i>Alice</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>25-14932</i>	17. INFORMANT <i>Mr. Charles Price 628 N. Fremont Ave.</i>		
18. <i>250.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>ASCD & Fibrillation</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>EVA</i> <i>diabetes mellitus</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>7/3/70</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>7/3/70</i> 19 <i>7/4</i> 19 <i>7/4</i> that (I) (we) last saw the deceased alive on <i>7/4</i> 19 <i>70</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward A. Hallen MD</i>			23B. DATE SIGNED <i>7/10/70</i>		23C. PHYSICIAN'S NAME (Type) <i>E. S. KALLINS MD</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>7-8-70</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>
24D. LOCATION (City, town, or county) (State) <i>Westport (Baltimore) Md.</i>			25A. DATE REC'D BY HEALTH DEPT. <i>JUL 13 1970</i>		
25B. NAME OF REGISTRAR <i>Robert E. Taylor, R.D.</i>			25C. FUNERAL DIRECTOR <i>Joseph L. Russ 2222 N. Park Ave.</i>		



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S-512

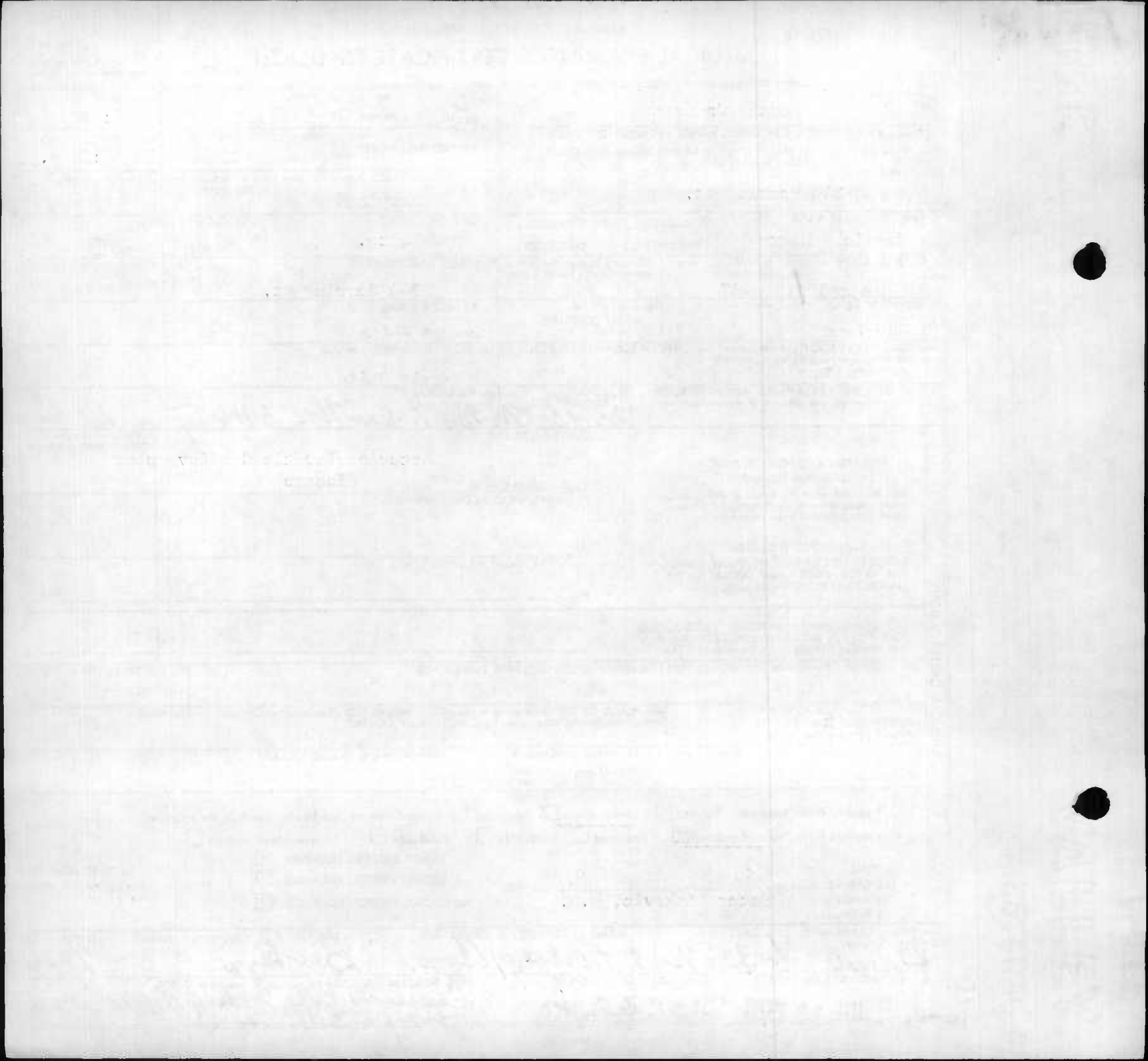
70 6989

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

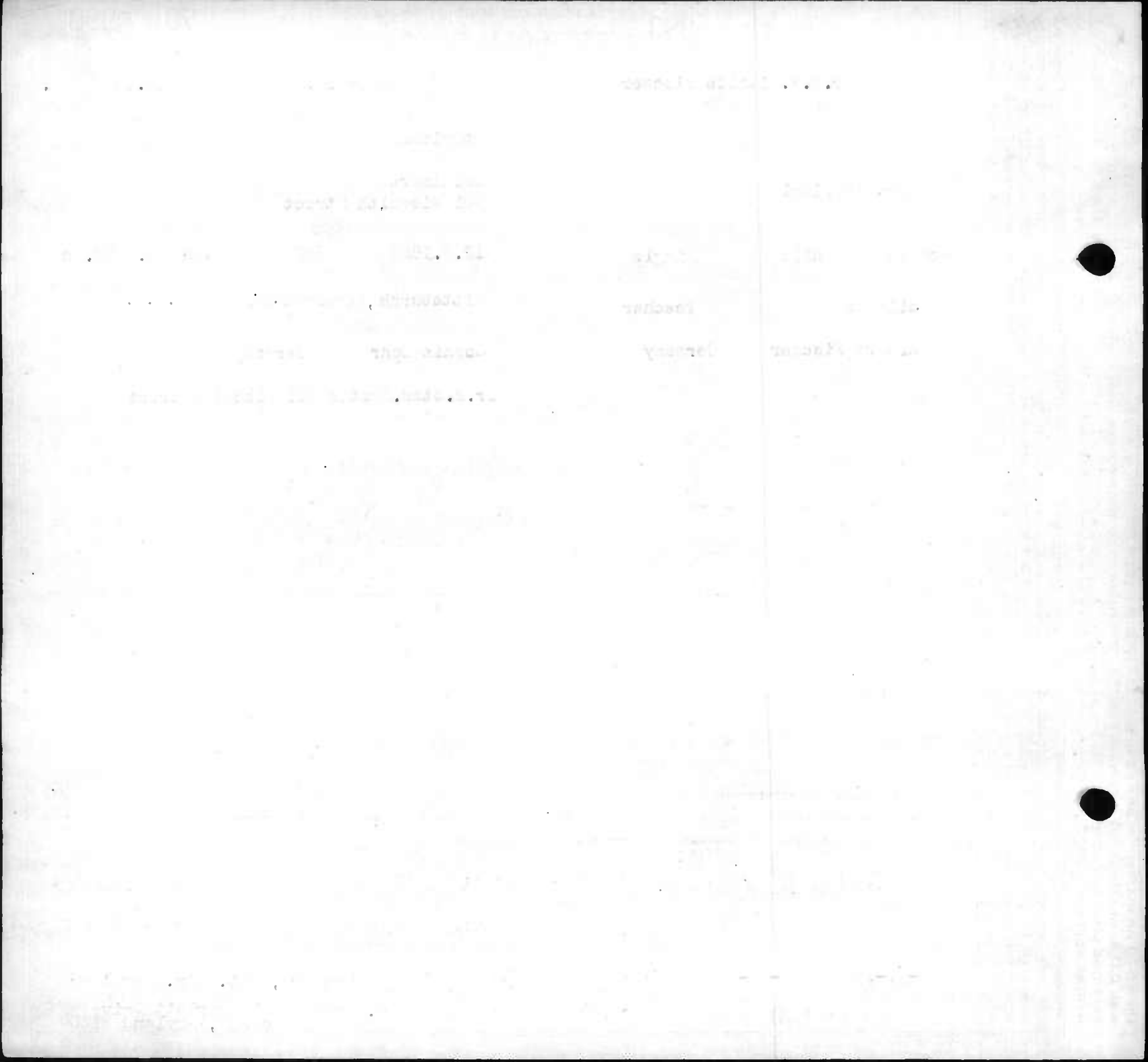
REG. NO. 70 6989

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Martha Sampson		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 6 28 70 6:50 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 344 Herring Ct.		3. DATE PRONOUNCED DEAD Month Day Year Hour 6 28 70 6:50 p. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 301	
6. SEX female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Sept 17/13		10. AGE (in years last birthday) 57	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Maggie White	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 24-23-4848		18. INFORMANT Mrs. Helen Hill 3404 Springdale Ave	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular disease		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/29/70					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 6-30-70		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. FUNERAL DIRECTOR Charles S. Lopez ADDRESS 512 N. Carroll St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

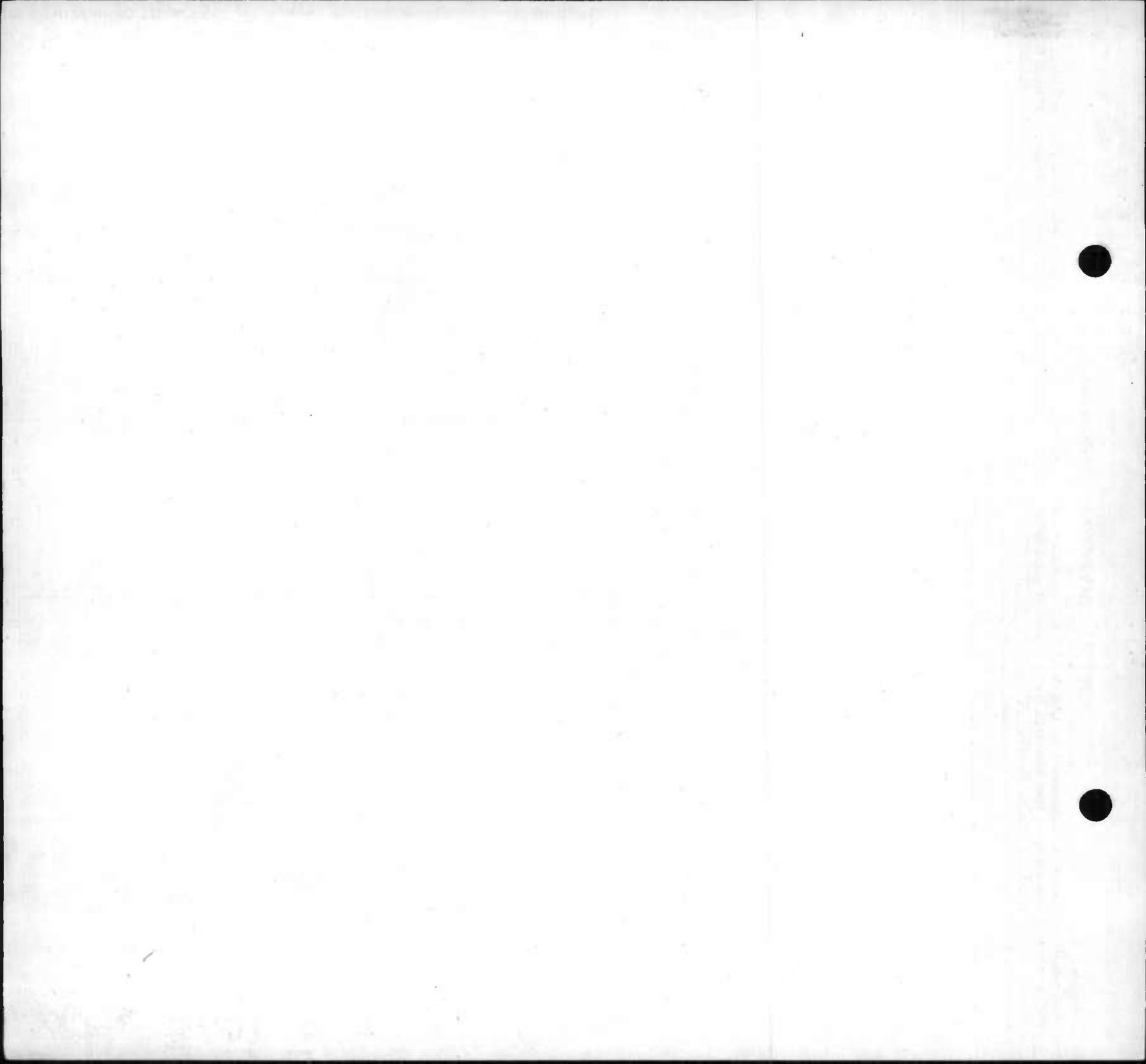
BIRTH NO. 70 6990		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 70 6990	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Sr. M. W. Vitalis Fischer		2. DATE AND HOUR OF DEATH July 10, 1970 10.15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 901 Aisquith Street			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single	8. DATE OF BIRTH 12.6.1882	9. AGE (In years lost birthday) 87	10. If Under 1 Yr. Months Days July 10. 10.15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10B. KIND OF BUSINESS OR INDUSTRY Teacher		11. BIRTHPLACE (State or foreign country) Pittsburgh, Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albert Fischer Germany		14. MOTHER'S MAIDEN NAME Sophia Dohr Germany	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-54-2060		17. INFORMANT ADDRESS Sr. M. Stan. Kostka 901 Aisquith Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) acute myocardial infarction DUE TO (B) arteriosclerotic Cardio-vascular disease DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION O -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from JUL 19 69 to 10 JUL 19 70, that (I) (we) last saw the deceased alive on 10 JUL 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Salvatore R. Donohue M.D.		23B. DATE SIGNED 11 JUL 70			
23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE		23D. ADDRESS M.D. 7418 STANMORE CT BALTIMORE 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-70		24C. NAME OF CEMETERY or CREMATORY Sisters Cemetery	
24D. LOCATION Glen Arm, Balt. Cty. Maryland		25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970			
25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR ADDRESS Raymond J. Carran 817 Scarlett Drive Towson, Maryland 21204			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

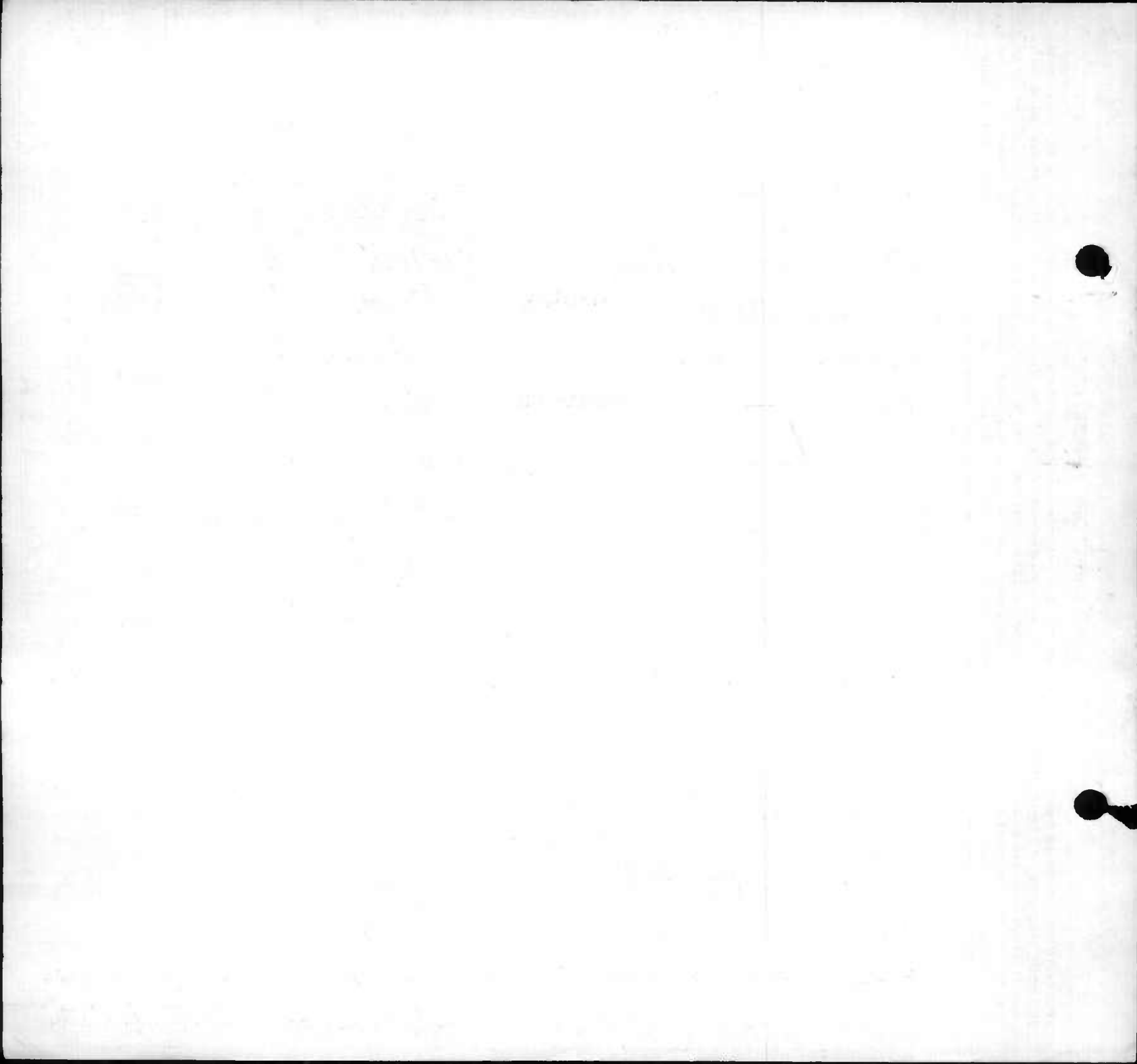
BIRTH NO. 70 6991				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 70 6991	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) MRS. MARY G. KIDWELL				2. DATE AND HOUR OF DEATH 12 JULY 1970 3.20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND AMERICA 2582			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1928 PARK SLEY AVE.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/27/100	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? AMERICA.				13. FATHER'S NAME CLAUDE LEBON			
14. MOTHER'S MAIDEN NAME SARAH BROCKHALL.				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 215-09-0041				17. INFORMANT Mr. Albert Kidwell			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC FAILURE. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. CARCINOMA OF LIVER. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/4/1970 to 7/12/1970, that (I) (we) last saw the deceased alive on 7/12/1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Chumsak Pruksapong M.D.				23B. DATE SIGNED 8/12/70.			
23C. PHYSICIAN'S NAME (Type) CHUMSAK PRUKSAPONG M.D.				23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/70		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		24D. LOCATION (City, town, or county) (State) Glen Burnie Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR John J. Conrad & Son Inc.		ADDRESS 2311 N. 1st St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				70 6992		Registered No. 70 6992	
BIRTH NO. 70 6992				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) John Francis Milttenberger				July 10, 1970 2 20 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL				A. STATE B. COUNTY Maryland Harford			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BET AIR 21014			
				D. STREET ADDRESS (If rural, give location) 406 CEDAR SPRING RD.			
5. SEX M	6. RACE Cau	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 11/29/38	9. AGE (In years last birthday) 31	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PERSONNEL MANAGER U.S. Govt.	11. BIRTHPLACE (State or foreign country) PENNY.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FRANCIS Milttenberger				14. MOTHER'S MAIDEN NAME DeLores May			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 106-32-9896		17. INFORMANT Chas & wife (Patricia)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 4-5-18 I PULMONARY Embolus				CAUSE OF DEATH (A) DUE TO Recurrent Pulmonary Emboli		INTERVAL BETWEEN ONSET AND DEATH Acute 1 month	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Thrombophlebitis 1 month.				(B) DUE TO Acute Renal Failure		5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 3 7/4/70		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent Pulmonary Emboli		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 7/8 1970 to 7/10 1970, that (I) (we) last saw the deceased alive on 7/10 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Donald T. Lewers				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>		23B. DATE SIGNED 7/10/70	
23C. PHYSICIAN'S NAME (Type) DONALD T. LEWERS				23D. ADDRESS M.D. 827 LINDEN AVE 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE July 14, 1970		24C. NAME OF CEMETERY or CREMATORY JEFFERSON Memorial Cemetery		24D. LOCATION (City, town, or county) (State) MEASANT HILLS, ALLEGHENY CO, PENNSYLVANIA	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Joseph William Foster		ADDRESS West Broadway Williams Street BET AIR, Maryland 21014	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 70 6993

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SHERYL Madigan

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

7

10

70

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 UNIVERSITY HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

July 10, 1970

6:10 A.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

ANNE ARUNDEL

6. SEX

Female

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Annapolis
Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

5210

9. DATE OF BIRTH

8-31-1931

10. AGE (In years
last birthday)

38

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

6 Catkin Place 1406 CATHYAN PLACE

11. BIRTHPLACE (State or foreign country)

EAU CLAIRE Wisc

12. CITIZEN OF

WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

VERNON E. LARSEN

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

14B. KIND OF BUSINESS OR INDUSTRY

HOME

15. MOTHER'S MAIDEN NAME

GREEN WARD

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)
YES 1953-1955

17. SOCIAL SECURITY NO.

18. INFORMANT

ALBERT W. MADIGAN # 5

ADDRESS

19. E812.1

CAUSE OF DEATH

Multiple traumatic injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about

home, farm, factory, street, office bldg., etc.)
Street

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR?
Forest Drive, Annapolis, Maryland 5200

22D. TIME (Month) (Day) (Year) (Hour)

OF INJURY
(APPROX.) 7-10-70 12:57 A, m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto-auto collision

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

7/10/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

7-14-70

24C. NAME OF CEMETERY or CREMATORY

LAKE VIEW

24D. LOCATION (City, town, or county)

EAU CLAIRE Wisc

(State)

25A. DATE REC'D BY HEALTH DEPT.

JUL 13 1970

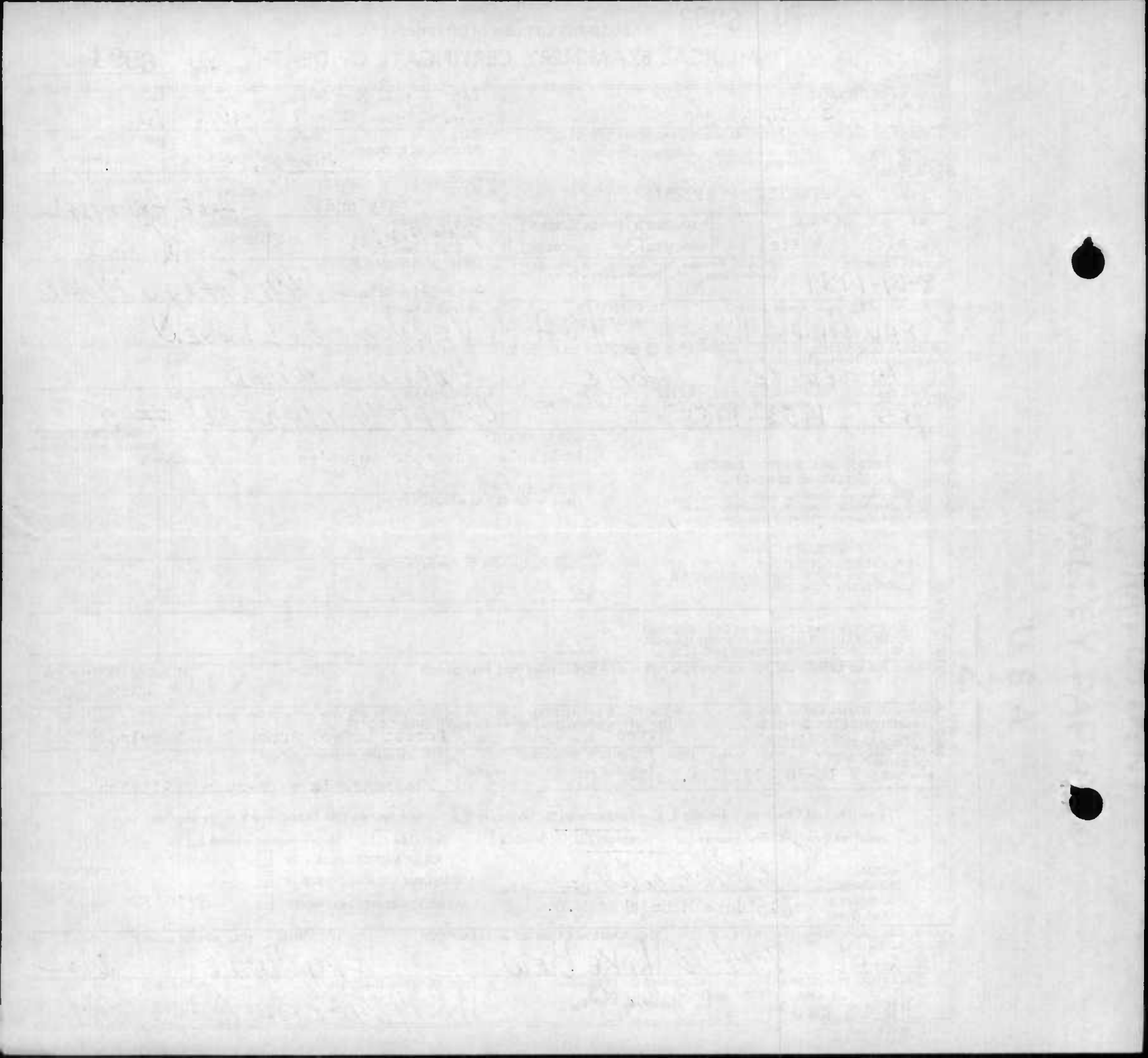
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

John M. Lathrop, Annapolis, Md.

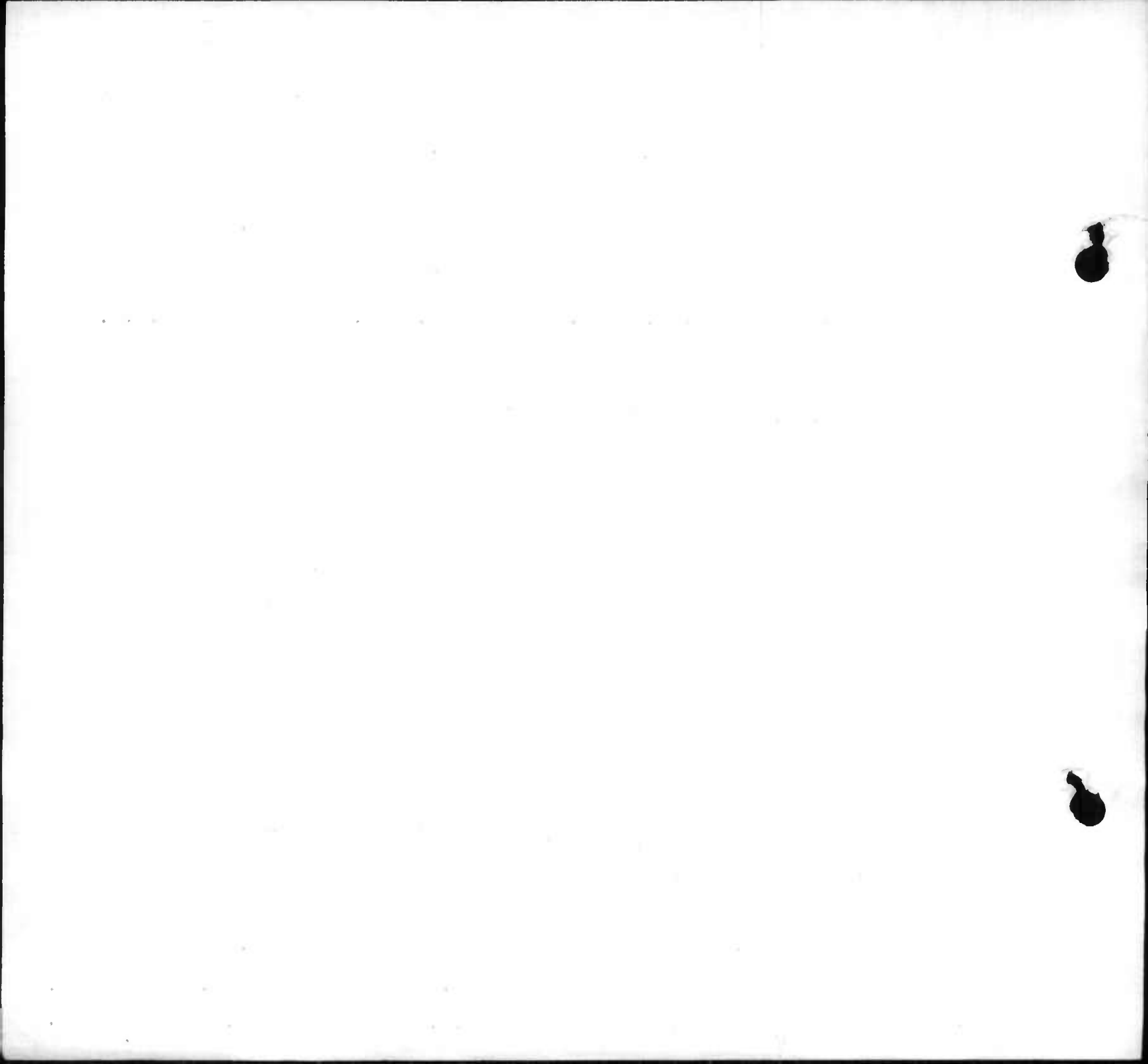
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6994	
K-523 70 6994				CERTIFICATE OF DEATH	
BIRTH NO. K-523			1. NAME OF DECEASED (Type or Print) Edward Leroy Knight		
2. DATE AND HOUR OF DEATH 7-11-70 5 A.M.			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md.		B. COUNTY 1203			
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 441 Ilchester Ave.					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-29-18	9. AGE (In years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY P. O. Dept.		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Bryan Knight	
14. MOTHER'S MAIDEN NAME Madeline White				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW II U. S. Army	
16. SOCIAL SECURITY NO. 216-07-6189		17. INFORMANT ADDRESS Madeline White Same			
18. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic Cardiovascular Disease (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 70 to July 11 1970 that (I) (we) last saw the deceased alive on July 9 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Fusting				23B. DATE SIGNED 7-13-70	
23C. PHYSICIAN'S NAME (Type) William H. Fusting				23D. ADDRESS 4230 Loch Raven Blvd.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 7-14-70		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem.	
24D. LOCATION Baltimore, Co.		24E. CITY, town, or county Md.		24F. STATE Md.	
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.	
25D. ADDRESS 4905 York Rd. Baltimore, Md. 21212					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 70 6995

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Jacquelyn Roche

2. DATE
OF
DEATHKnown ☐
Estimated ☐Month
Day

Year

Hour 7:50
= P.M.

7

12

70

P.M.

3. DATE

PRONOUNCED DEAD

Month

Day

Year

Hour

7

12

70

7:50 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

2706

6. SEX

female

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

5-29-53

10. AGE (in years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2606 Evergreen Avenue

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Clinton J. Roche, Sr.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

School

15. MOTHER'S MAIDEN NAME

Doris Kitzmiller

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs. Clinton Roche,

Same

19.

E 81213

CAUSE OF DEATH

Multiple injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Road Road

22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?Old North Point Rd. &
Lodge Forest Rd.22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

7 12 70

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒22F. HOW DID INJURY OCCUR? Passenger on rear of
motorcycle - crossed over double yellow
line into path of a car.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Peter Lipkovic, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

7/13/70

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7-16-70

24C. NAME of CEMETERY or CREMATORY

Balto. Nat'l. Cemetery

24D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

JUL 13 1970

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

H.W. Jenkins Sons Co. 4905 York Rd.

ADDRESS

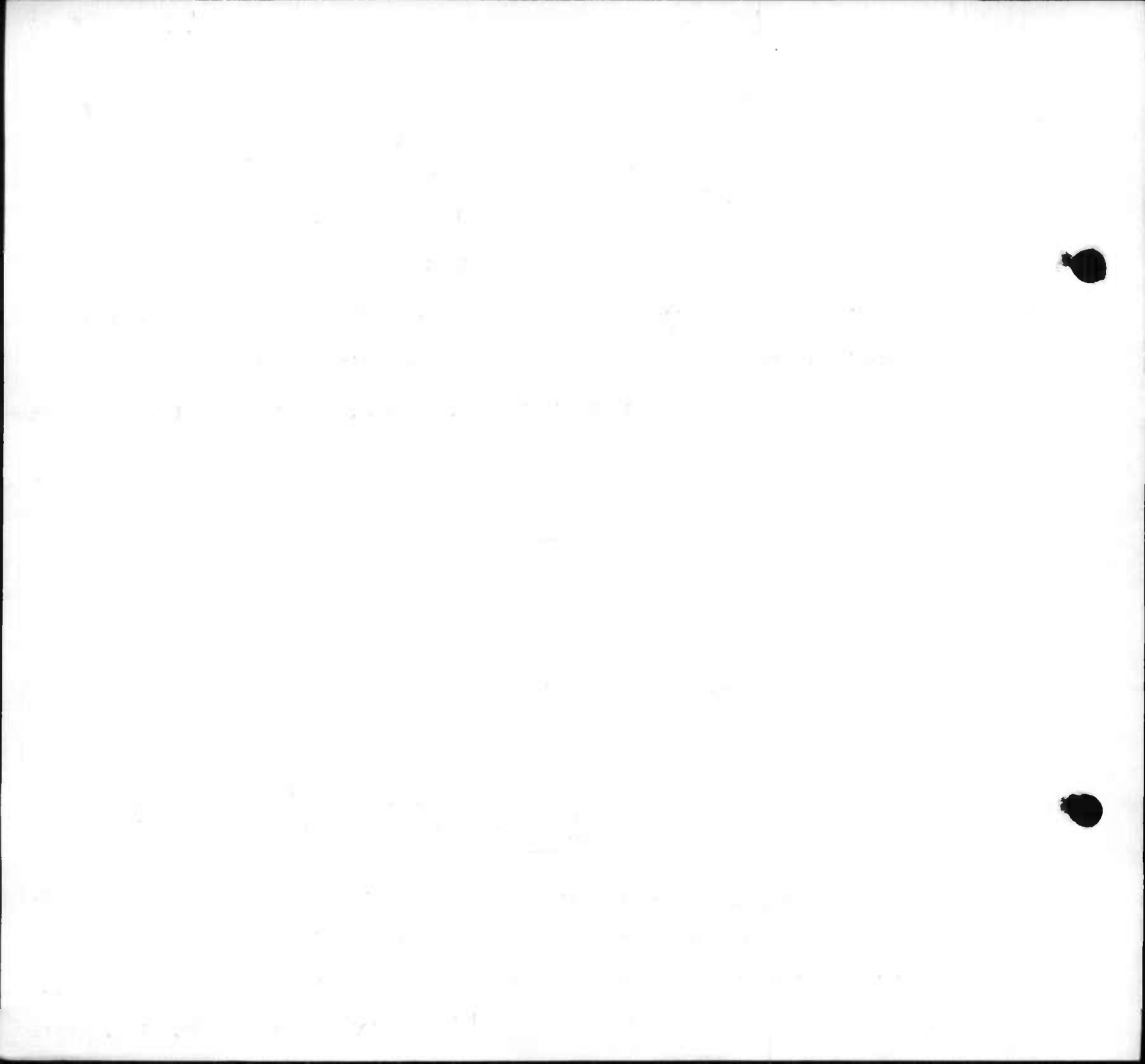
Balto., Md. 21212

VS 153 7-15-70 M. H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>B-552 70 6996</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>70 6996</p> <p>REG. NO.</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>P. BERTHE GUNNING</i></p>		<p>2. DATE AND HOUR OF DEATH <i>JULY 10 1970 9 P. M.</i></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><i>90 Edgewood Nursing Home</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <i>Maryland</i> B. COUNTY <i>2714</i></p> <p>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <i>216 Kendall Road</i></p>	
<p>5. SEX <i>F</i></p>	<p>6. RACE <i>W</i></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <i>4-15-1899</i></p>
<p>9. AGE (in years last birthday) <i>71</i></p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i></p>
<p>11. BIRTHPLACE (State or foreign country) <i>Roanne, France</i></p>		<p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>13. FATHER'S NAME <i>Antonine Jaunon</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Josephine Cornil</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p>		<p>16. SOCIAL SECURITY NO. <i>212-32-0387</i></p>	<p>17. INFORMANT ADDRESS <i>Mr. Rene J. Gunning 606 Highwood Drive</i></p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <i>Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>5 months</i></p> <p>(B) <i>Carcinoma of rectum</i> DUE TO, OR AS A CONSEQUENCE OF: <i>7 years</i></p> <p>(C) _____</p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <i>May 1970</i></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>intestinal obstruction</i></p>	<p>20A. AUTOPSY? (Yes or No) <i>no</i></p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (H) (this hospital) attended the deceased from <i>June 1 1970</i> to <i>July 10 1970</i> that (H) (we) lost saw the deceased alive on <i>July 10 1970</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>Frederick J. Vollmer MD</i></p>		<p>23B. DATE SIGNED <i>July 10 1970</i></p>	<p>Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/></p>
<p>23C. PHYSICIAN'S NAME (Type) <i>FREDERICK J. VOLLMER MD</i></p>		<p>23D. ADDRESS <i>6100 YORK RD BALTO MD 21212</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p>	<p>24B. DATE <i>7-15-70</i></p>	<p>24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National</i></p>	<p>24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <i>JUL 13 1970</i></p>	<p>25B. NAME OF REGISTRAR <i>Hubert E. Taylor, MD</i></p>	<p>25C. FUNERAL DIRECTOR ADDRESS <i>Henry W. Jenkins & Sons Co 4905 York Road Balto., Md. 21212</i></p>	



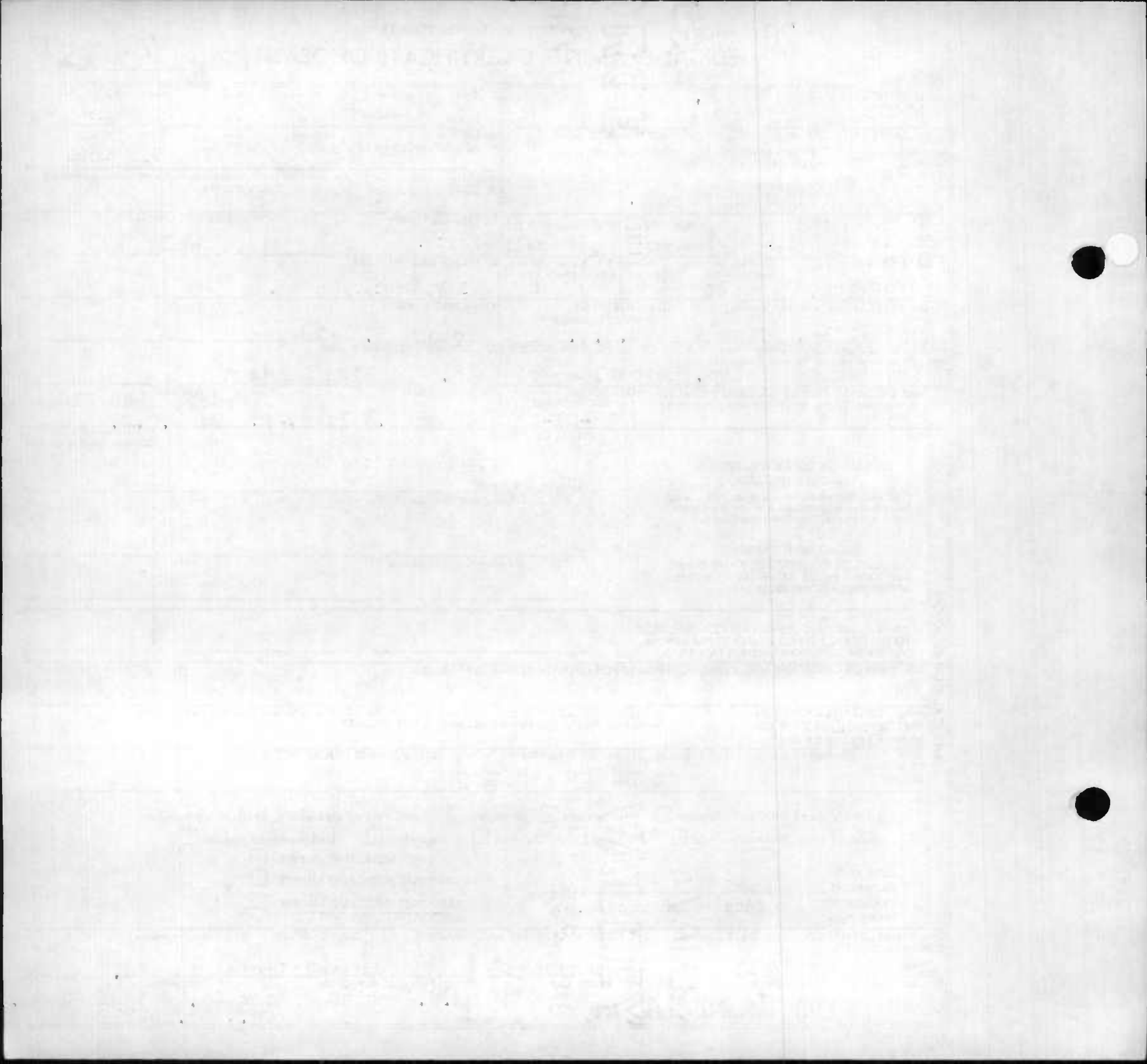
BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

70 6997

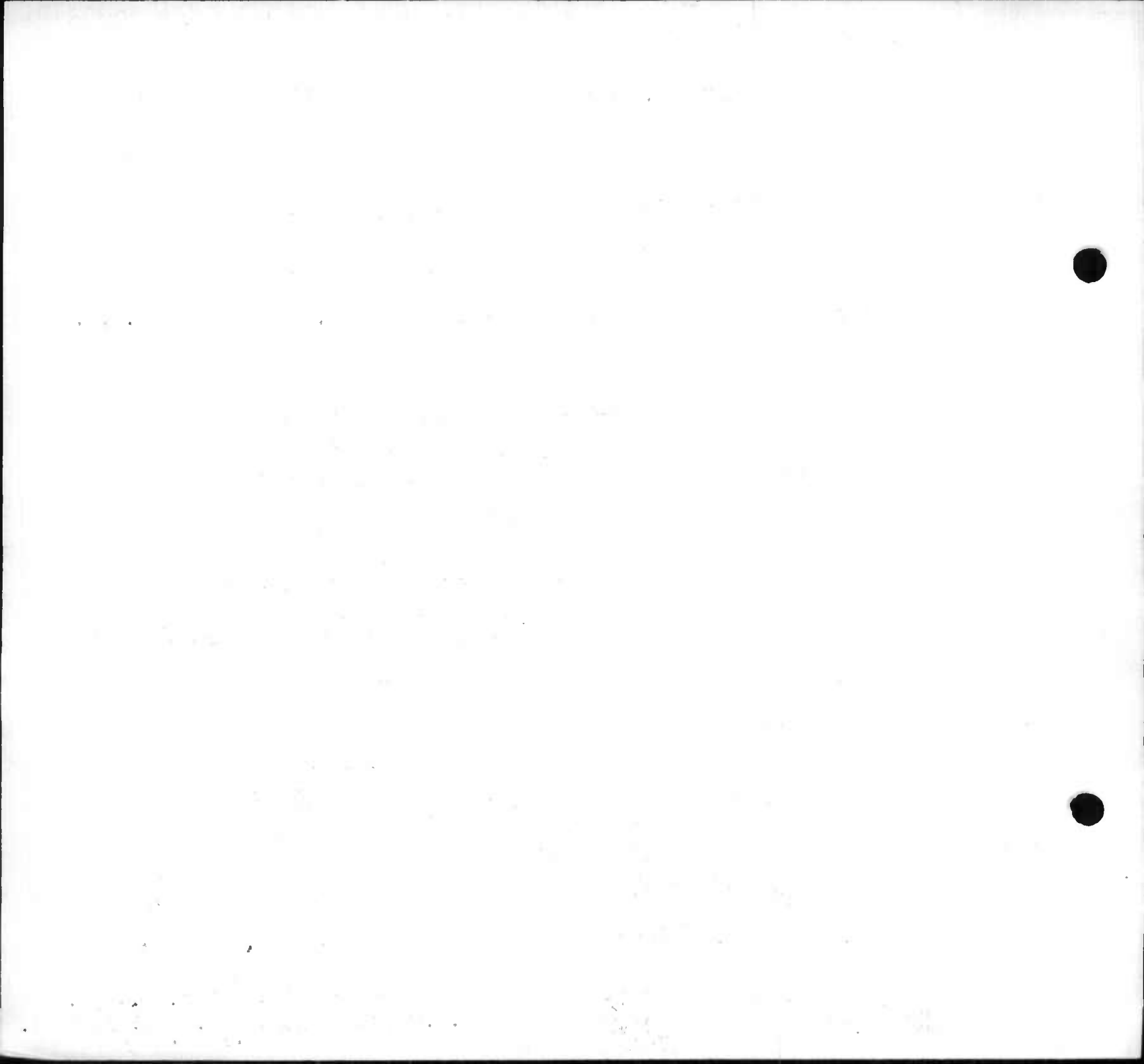
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Lillian Poe</u>		2. DATE OF DEATH Known <input type="checkbox"/> Month <u>7</u> Day <u>12</u> Year <u>70</u> Hour <u>12:45</u> P.M. Estimated <input type="checkbox"/> 7 12 70 12:45 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> 3929 Canterbury Rd.		3. DATE PRONOUNCED DEAD Month <u>7</u> Day <u>12</u> Year <u>70</u> Hour <u>12:45</u> P.M.	
6. SEX female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1201</u>	
9. DATE OF BIRTH <u>12/25/1889</u>		10. AGE (In years last birthday) <u>80</u> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Huntsville, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert S. Halsey</u>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Balto. Photo & Blue Print Co.</u>	
15. MOTHER'S MAIDEN NAME <u>Lillian Landman</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
17. SOCIAL SECURITY NO. <u>215-01-2476</u>		18. INFORMANT <u>James D. Halsey, Jr.</u> ADDRESS <u>Federal Bar Bldg Wash. D.C.</u>	
19. <u>412.4</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <u>No</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Peter Lipkovic, M.D.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Peter Lipkovic, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7/13/70</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>7/13/70</u>	
24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 13 1970</u>		25B. NAME OF REGISTRAR <u>Robert E. Farber, M.D.</u>	
25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Rd. Balto., Md. 21212</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

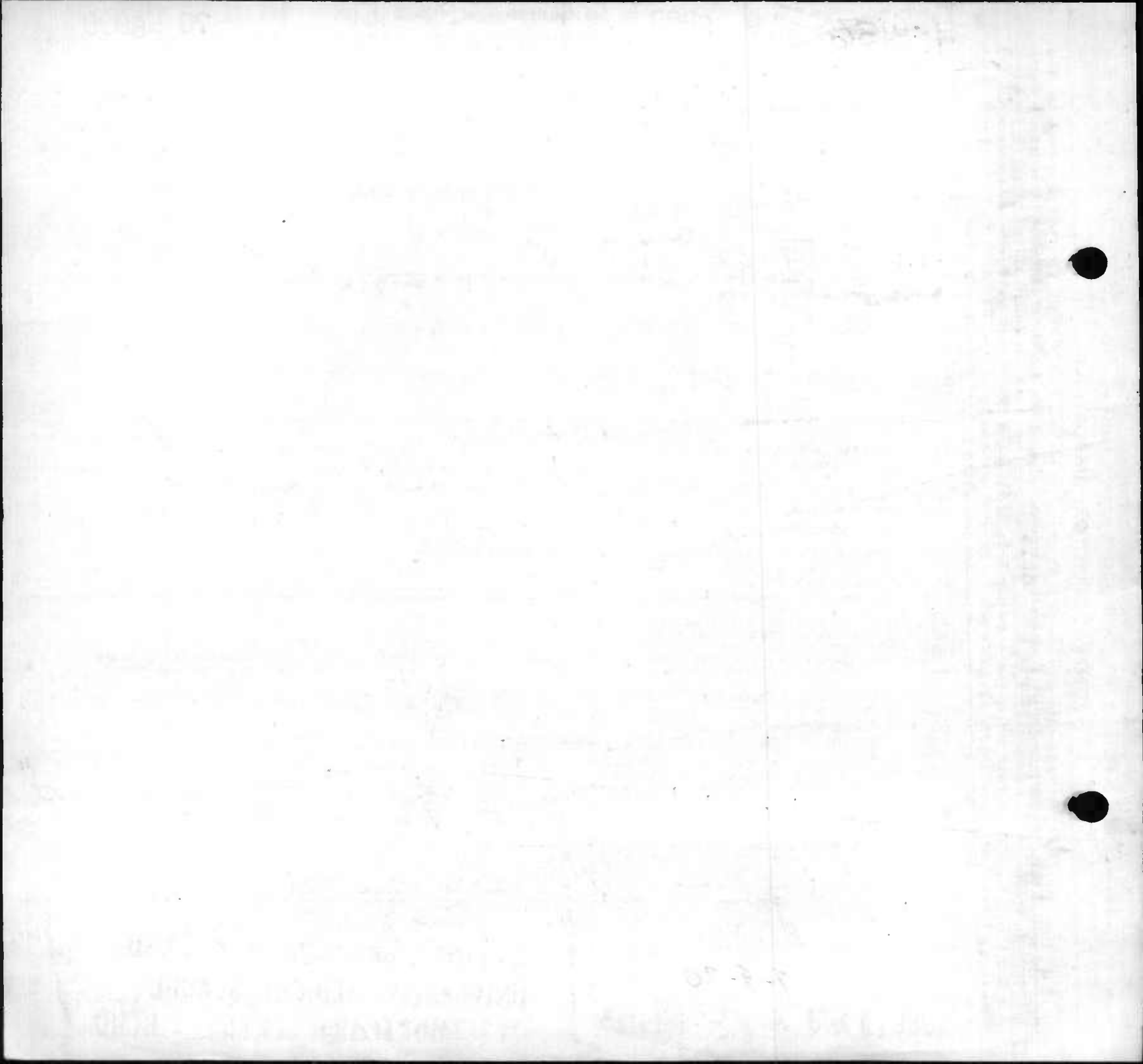
70 6998		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		70 6998	
M-243				REG. NO. _____	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <div style="text-align: center; font-size: 16pt; font-weight: bold;">Dorothy E. MacGoldrick</div>		2. DATE AND HOUR OF DEATH <div style="text-align: center; font-size: 16pt; font-weight: bold;">7/8/1970 11:30 P.M.</div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="text-align: center; font-size: 16pt; font-weight: bold;">4022 The Alameda</div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <div style="text-align: center; font-size: 16pt; font-weight: bold;">Maryland</div> B. COUNTY <div style="text-align: center; font-size: 16pt; font-weight: bold;">901</div>		C. CITY OR TOWN <div style="text-align: center; font-size: 16pt; font-weight: bold;">Baltimore</div> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <div style="text-align: center; font-size: 16pt; font-weight: bold;">4022 The Alameda</div>		5. SEX F <input checked="" type="checkbox"/> W <input type="checkbox"/>		6. RACE W <input checked="" type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center; font-size: 16pt; font-weight: bold;">9/23/1906</div>		9. AGE (in years last birthday) <div style="text-align: center; font-size: 16pt; font-weight: bold;">63</div>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 16pt; font-weight: bold;">Housewife</div>		10B. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center; font-size: 16pt; font-weight: bold;">Own Home</div>		11. BIRTHPLACE (State or foreign country) <div style="text-align: center; font-size: 16pt; font-weight: bold;">Baltimore, Md.</div>	
12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 16pt; font-weight: bold;">U.S.A.</div>		13. FATHER'S NAME <div style="text-align: center; font-size: 16pt; font-weight: bold;">William David Gear</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 16pt; font-weight: bold;">Louella Elphring</div>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="text-align: center; font-size: 16pt; font-weight: bold;">No</div>		16. SOCIAL SECURITY NO. <div style="text-align: center; font-size: 16pt; font-weight: bold;">213-16-5662</div>		17. INFORMANT <div style="text-align: center; font-size: 16pt; font-weight: bold;">Peter MacGoldrick (Same)</div>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <div style="text-align: center; font-size: 16pt; font-weight: bold;">Diabetes mellitus</div>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <div style="text-align: center; font-size: 16pt; font-weight: bold;">Advanced Nephrosclerosis</div>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center; font-size: 16pt; font-weight: bold;">25-30 days</div>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <div style="text-align: center; font-size: 16pt; font-weight: bold;">Diabetes gangrene left foot</div>		(B) DUE TO, OR AS A CONSEQUENCE OF: <div style="text-align: center; font-size: 16pt; font-weight: bold;">Arteriosclerotic Heart Disease</div>			
(C) DUE TO, OR AS A CONSEQUENCE OF: <div style="text-align: center; font-size: 16pt; font-weight: bold;">Congestive Failure</div>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <div style="text-align: center; font-size: 16pt; font-weight: bold;">Hypertensive Cardiovascular Disease</div>					
19A. DATE OF OPERATION <div style="text-align: center; font-size: 16pt; font-weight: bold;">None</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <div style="text-align: center; font-size: 16pt; font-weight: bold;">None</div>		20A. AUTOPSY? (Yes or No) <div style="text-align: center; font-size: 16pt; font-weight: bold;">No</div>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <div style="text-align: center; font-size: 16pt; font-weight: bold;">No</div>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <div style="text-align: center; font-size: 16pt; font-weight: bold;">None</div>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <div style="text-align: center; font-size: 16pt; font-weight: bold;">None</div>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <div style="text-align: center; font-size: 16pt; font-weight: bold;">None</div>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <div style="text-align: center; font-size: 16pt; font-weight: bold;">None</div>		22. I certify that (I) (this hospital) attended the deceased from <div style="text-align: center; font-size: 16pt; font-weight: bold;">July 1 1970</div> to <div style="text-align: center; font-size: 16pt; font-weight: bold;">July 8 1970</div> that (I) (we) lost saw the deceased alive on <div style="text-align: center; font-size: 16pt; font-weight: bold;">7/6/70</div> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <div style="text-align: center; font-size: 16pt; font-weight: bold;">Dr. Donald W. Mintzer</div>		23B. PHYSICIAN'S NAME (Type) <div style="text-align: center; font-size: 16pt; font-weight: bold;">Dr. Donald W. Mintzer</div>		23C. ADDRESS <div style="text-align: center; font-size: 16pt; font-weight: bold;">3009 Evergreen Ave.</div>	
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 16pt; font-weight: bold;">Burial</div>		24B. DATE <div style="text-align: center; font-size: 16pt; font-weight: bold;">7/11/70</div>		24C. NAME OF CEMETERY or CREMATORY <div style="text-align: center; font-size: 16pt; font-weight: bold;">Parkwood</div>	
24D. LOCATION (City, town, or county) (State) <div style="text-align: center; font-size: 16pt; font-weight: bold;">Parkville, Balto. Co., Md.</div>		25A. DATE REC'D BY HEALTH DEPT. <div style="text-align: center; font-size: 16pt; font-weight: bold;">JUL 13 1970</div>		25B. NAME OF REGISTRAR <div style="text-align: center; font-size: 16pt; font-weight: bold;">Robert E. Taylor, M.D.</div>	
25C. FUNERAL DIRECTOR <div style="text-align: center; font-size: 16pt; font-weight: bold;">H.W. Jenkins & Sons Co.</div>		25D. ADDRESS <div style="text-align: center; font-size: 16pt; font-weight: bold;">4905 York Rd. Balto., Md. 21212</div>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 70 6999
L-236 70 6999		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) VIRGINIA DOWNS LESTER		2. DATE AND HOUR OF DEATH 7/2/70 9 30 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 0004 Woodson Rd.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2768 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1004 Woodson Rd.		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 63	9. AGE (In years last birthday) 63 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante myocardial infarct non ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. AS + 1		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1964 to 7/2 19 70 , that (I) (we) last saw the deceased alive on 6/15 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Andryan MD		23B. DATE SIGNED 7/2/70		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) F. M. DUGAN MD		23D. ADDRESS 15 E. Biddle St. BALTO. MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) 7-9-70		24B. DATE 7-9-70		
24C. NAME OF CEMETERY OR CREMATOR ANATOMY BOARD OF MARYLAND		24D. ADDRESS UNIVERSITY MEDICAL SCHOOL		
25A. DATE REC'D BY HEALTH DEPT. JUL 13 1970		25B. NAME OF REGISTRAR John E. Taylor		
		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>70 7000</u>	
D-500 <u>70 7000</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>DONOH, FLOSSYE MAYO</u>			2. DATE AND HOUR OF DEATH <u>JULY 12, 1970</u> <u>1:55 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>21229</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSPITAL, WILKENS & CATON AVENUES-BALTO; MD. 21229</u>			C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>11/11/90</u> 9. AGE (in years lost birthday) <u>79</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		
13. FATHER'S NAME <u>WINFIELD MURPHY</u>			14. MOTHER'S MAIDEN NAME <u>GLENNIE MURPHY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>212015395</u>		
17. INFORMANT <u>BALTIMORE, MD. 21229</u> ADDRESS <u>ST. AGNES HOSPITAL, WILKENS & CATON AVE</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral ischemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebral Thrombosis</u> <u>ASCVD, Diabetes Mellitus</u> <u>C.H. Failure</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 18</u> 19 <u>70</u> to <u>JULY 12</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>JULY 12</u> 19 <u>70</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George S. Patrick</u>			23B. DATE SIGNED <u>07-12-70</u>		
23C. PHYSICIAN'S NAME (Type) <u>GEORGE S. PATRICK</u>			23D. ADDRESS <u>ST. AGNES HOSPITAL, WILKENS & CATON AVE BALTIMORE MARYLAND 21229</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-15-70</u>		24C. NAME of CEMETERY or CREMATORY <u>Dorchester Memorial Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Dorchester County, Maryland</u>		24E. LOCATION (State) <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JUL 14 1970</u>		25B. NAME OF REGISTRAR <u>E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>	
25D. ADDRESS <u>4107 Wilkens Ave.</u>		25E. ADDRESS <u>21229</u>			

